

VERMONT STATE PLAN ON AGING

October 1, 2002

through

September 30, 2005

**AS REQUIRED BY
THE OLDER AMERICANS ACT OF 1965,
AS AMENDED THROUGH 2000**

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This document is available upon request in large print, Braille, on disk, or on audiocassette. Please contact the Department for further information.

VERIFICATION OF INTENT

The State Plan on Aging is hereby submitted for the State of Vermont for the three-year period October 1, 2002 through September 30, 2005.

The plan includes assurances and plans to be conducted by the Vermont Department of Aging and Disabilities under provisions of the Older Americans Act, as amended, during the period identified. The State Agency named above 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 the elderly and family caregivers in the state.

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 Secretary on Aging.

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

(Signed) _____ (Date) _____
Patrick Flood, Commissioner,
Department of Aging and Disabilities
State of Vermont

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PURPOSE OF STATE PLAN

In order to plan for the on-going and future needs of elders in Vermont and to meet the requirements of Section 307 of the Older Americans Act, the Department of Aging and Disabilities, the designated State Unit on Aging for Vermont has prepared a State Plan for submission to the federal Administration on Aging. Vermont has opted to present a 3-Year State Plan for the period October 1, 2002 through September 30, 2005.

The State is required by regulation to:

- (a) develop a State Plan for submission to the Assistant Secretary for Aging;
- (b) administer the State Plan in accordance with Title III of the Older Americans Act, 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 Older Americans Act;
- (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.

This plan reflects the Department's commitment to implementation of Act 160, an historic law passed in 1996 which allows the Department to increase investments in community based systems of long-term care using Medicaid dollars not expended for nursing facility care. While much progress has been made, our intent is to continue the expansion of the range of choices available to consumers, which support their independence to the greatest extent possible and to provide greater options to those individuals who have need of long term care services. In addition, the State Plan incorporates the broader vision and goals of the Department into the body of the plan and includes feedback and comments received during the public hearing and comment period.

Finally, the State Plan describes the values, available resources, goals and strategies designed to achieve Departmental goals and as such offers a framework for the ongoing operations of programs funded through the Older Americans Act.

MISSION STATEMENT

The Department of Aging and Disabilities' mission is to improve the quality of life for Vermont's older persons and persons with disabilities, and to foster the development of a comprehensive and coordinated approach to the provision of community based systems of service for both populations. Our goal is to enhance the ability of these individuals to live as independently as possible, actively participating in and contributing to their communities.

As prescribed in Section 305 of the Act, the Department will target services to older individuals who:

- are in greatest economic and social need
- are at greatest risk of loss of independence due to frailty, severe disabilities and/or chronic conditions
- reside in rural areas
- have Alzheimer's Disease or a related disorder and the caregivers of those individuals and/or
- are older low-income minority individuals

While we are dedicated to providing services to those in greatest need, a significant percentage of Vermont's elders may not fit into one or more of the specific target groups noted above. The five Area Agencies on Aging (AAAs) provide assistance to many older individuals who have short term needs, or require help which is intermittent in nature. In fact, thousands of elders are able to retain their independence because of ongoing case management, nutrition services and other OAA services that are not crisis driven, but more preventive in nature. Without such assistance many would eventually be at greater risk for deteriorating health and/or economic status, either of which can lead to loss of independence. In addition, many AAA clients successfully regain their independence after a stay in a hospital or nursing home, as a result of case management support, nutrition services and other interventions.

Our mission must include work with the Area Agencies on Aging and their community partners to provide services, which prevent poverty, isolation, poor health and premature institutionalization. We are committed to assisting communities in identifying prevention models. We will assist in planning for, supporting and implementing community based programs, services and initiatives which offer front line support to assist elders in retaining their maximum level of independence, because we recognize this as an essential component for successful aging and independent living.

The Department will conduct the following activities under the State Plan:

- Provide for a comprehensive and coordinated system of services for elders;
- Advocate for their rights, benefits and service needs, with the assistance of public and private resources and organizations whose services and activities make a difference in the well-being of older persons;
- Identify older individuals who are eligible for assistance under the Act, and inform older persons and the general public of the services available to meet their needs;
- Recognize and correct any gaps in ability to identify or provide services to meet these needs;
- Develop or support the development of a variety of services and systems of care which may be funded through grants, contracts or community contributions, including those which focus on prevention initiatives;
- Designate Area Agencies on Aging for the purpose of carrying out the mission of the Older Americans Act;
- Evaluate these agencies to ensure that their activities are in keeping with the Act and the mission of the Department; and
- Ensure that resources made available to the Area Agencies on Aging under the Older Americans Act are used to carry out the mission of the Act as it is described in applicable law, regulation and State Agency policy.

Vermont's Department of Aging and Disabilities is the sole state agency responsible for administration of the State Plan on Aging. As described within the Older Americans Act, Title III, Section 301, and Section 1321.7 of the Rules and Regulations the Department must:

- Develop greater capacity and foster the development of comprehensive and coordinated systems which secure and maintain maximum independence and dignity in a home environment for older individuals capable of self care, with appropriate supportive services;
- Remove individual and social barriers to economic and personal independence for older individuals;
- Provide a continuum of care for vulnerable older individuals; and
- Secure the opportunity for older individuals to receive in-home and community based long-term care services.

STATEMENT OF VALUES

This State Plan reflects a process begun several years ago when the Department began to reevaluate the system of aging and long-term care services in Vermont. We believe our efforts have paid off in a number of important ways, putting the state on the road to a better-integrated and coordinated system.

In reevaluating our system of services we identified the need to find additional service funds as a first step. The passage of Act 160 was intended to expand the home and community-based system by infusing new funding previously reserved for institutional care, thereby "shifting the balance" of expenditures from nursing homes to home and community based services. Since its implementation in 1996, Vermont has enjoyed enormous success in this endeavor and today Vermonters have more choices and options to receive the care and services that they need to remain in their community. Over the years, we have seen nursing home occupancy decline as community-based options expand and develop. In a 2000 survey, consumers of long-term care services expressed overwhelming satisfaction and approval for the programs in which they participated; however, they were far less satisfied than the general population with the amount of choice and control they had in planning for their services. In addition, the survey indicated that long-term care consumers may also experience a lesser quality of life than the general public. Based on these findings, it is clear that the efforts to "shift the balance" and to provide even greater choices and control must continue. Area Agencies on Aging and their community partners serve as key partners in this endeavor.

In stating our values we recognize aging as a universal experience, though not necessarily predictable in its course. While aging related changes often result in chronic conditions, most elders are able to successfully age in place with a high degree of independence.

The challenges of aging are many. For those who experience chronic conditions, these conditions frequently have a multiplier effect, impacting health, cognition, economic status and other indicators of well-being. Such changes often require a new approach, different plans, and significant adjustments in life style and, regardless of the reasons for change, often lack clear points of transition. Perhaps the greatest challenge lies in planning for and responding positively to change when it is needed, whether as an individual or a system of services and providers.

The following values respond to the universality of the aging process and the unique characteristics of the individual. These values describe how the Department envisions a consumer responsive long-term care system of service. These values support:

- An emphasis on self-determination, independence and autonomy for the individual.
- Respect for individual rights, strengths, values and choices.

- Services designed to meet individual needs and prioritized to ensure that those older individuals at greatest need are targeted for assistance.
- Advocacy in support of the individual's continued connections to family and community, to decrease or eliminate any segregation by age, disability or income.
- A holistic approach to designing systems of service which recognize the individual as a whole human being, with a diversity of needs from the social and health to the spiritual.
- Recognition of the role that prevention programs can play in developing a culture and service delivery system that supports successful aging and independent living.
- Security and safety balanced against the principles of negotiated risk and an individual's right to make his/her own choices.

The message expressed in the introduction to the Department's Legislative Oversight Report of January 1998 remains relevant and vital today and for our work in the future:

“We know that consumers thirst for change. Overwhelmingly, they express a desire to remain at home when faced with a long illness or disabling condition. Studies from the Robert Wood Johnson Foundation reveal that 30% of the chronically ill would rather die than go into a nursing home. A survey conducted by the Vermont AARP shows that more than 90% of elders want government to help them stay at home, instead of compelling them to move to a nursing home to receive long-term care.

Now, as we craft Vermont's long-term care policy for the 21st Century, we have a unique opportunity to respond to these consumer imperatives, to reshape our priorities and redefine our long-term care system, and, in the process, to give real meaning to our oft expressed commitment to community-based care. In a sense, we are designing Vermont's long-term care system for the future by affirming the truth of the principles first declared a quarter-century ago.

Act 160 is the contemporary embodiment of this commitment. It gives voice to the principles of consumer choice and mandates funding of community-based alternatives.”

VERMONT'S OLDER POPULATION

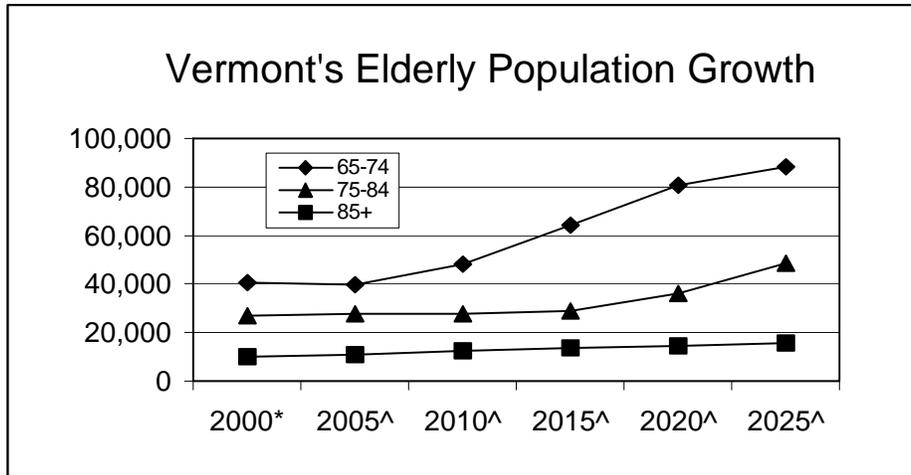
The United States is an aging society, a fact of which we are well aware. In 2000, the U.S. Census Bureau estimated the number of older adults (those 65+) at 35 million, or 12.4% of the total population. Current projections show this number growing to 53 million or 16.4% by 2020. By 2030, 20% of all Americans will be an older adult. In addition, we are living longer- much longer than previous generations. For example, in 1900 the life expectancy was 28 years shorter than it is today.

How does Vermont compare to this national trend? (NOTE: Sources for this data are listed at the end of the document. Graphs illustrative of demographic information are included in this section).

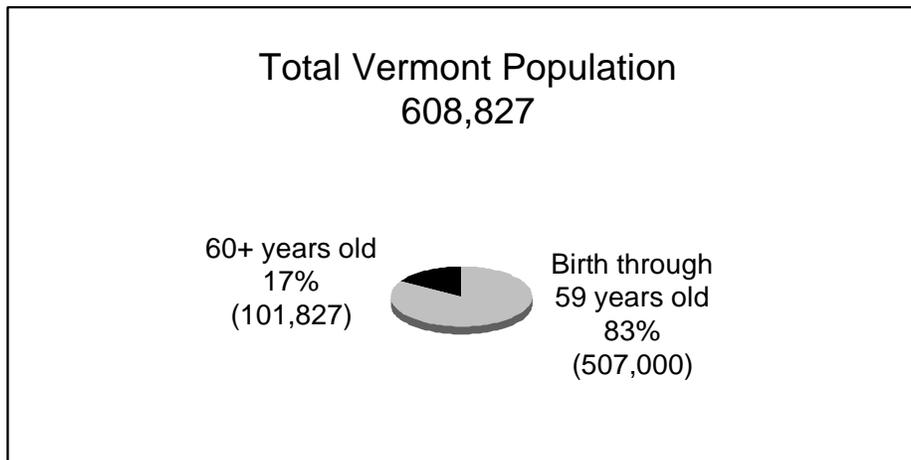
Demographics of Vermont's Aging Population

Population Trends¹

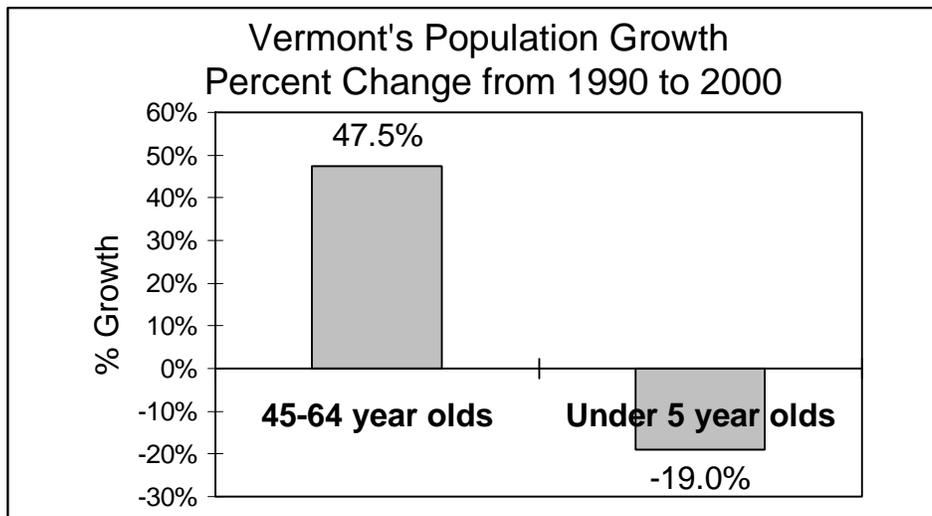
- We anticipate a significant increase in those aged 65-74 by 2015.



- The number of Vermonters over the age of 60 grew from 88,432 in 1990 to 101,827 in 2000, an increase of 13,395 or 15.15%.



- Compared to 1990, the percentage of those over 60 rose from 16% to 17%.
- The number of those 75 and older grew to 47.5% of the total population over age 65, compared to 44% in 1990.
- Between 1990 and 2000, the numbers of ‘old old’, those aged 85 and older, grew from 8.4% to 9.8% of the over 60 population.
- The 45 to 64 year old age group is the fastest growing segment of Vermont's population with a growth rate of 47.5% from 1990 to 2000, while the population of children five years of age and under declined by 19% during the same period.



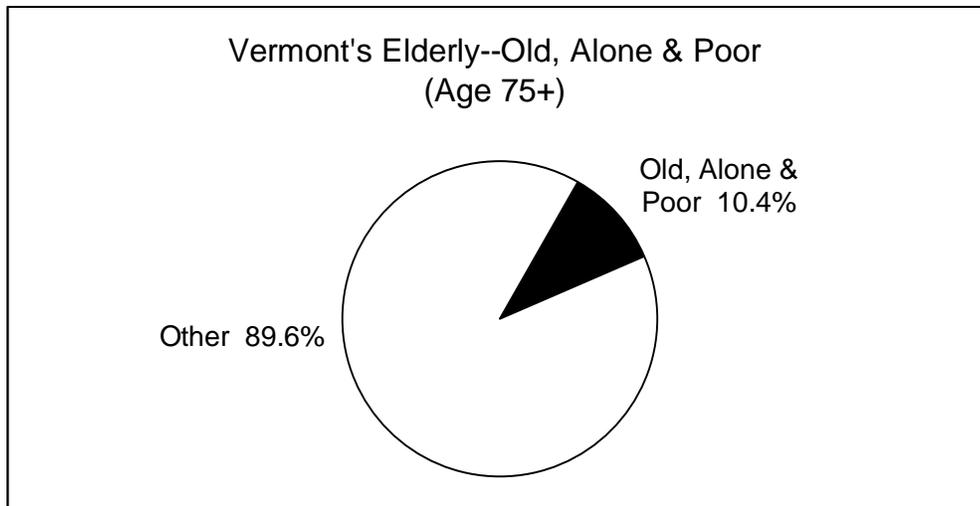
Rurality

- With the exception of Chittenden County, all of Vermont is considered to meet the federal definition of “rural.” 83,328 Vermont residents age 60 and over reside in these rural settings. This represents 81.8% of the elder population in Vermont. This is comparable to national data, which shows only 21% of the older population living in large cities.
- Rural elders are more likely to live in poverty than those in metropolitan regions because of lower lifetime earnings, investments and savings, as well as lower social security benefits and other pensions.²
- Rural elders are more likely to be married, but are less educated and in poorer health than elders living in more urban settings. They are more likely to own their own homes; however, the value of their homes is less than homes in urban areas.³
- Rural elders have less access to key services such as health care, social services and housing. The rural elder housing that is available is generally in poorer condition than that in urban areas. Rural elders usually have to travel farther to access these key resources, and yet at the same time, they have less access to transportation. Because of this, many rural elders have unmet needs.⁴

- Based on our projections 10,230 rural Vermont elders over the age of 60 are living below 125% of poverty. This represents an 8.45% increase from 1996. (NOTE: Refer to the state funding formula and OAP detail on pp. 67 - 70 of this document.)
- Pursuant with the requirements of the Older Americans Act, the State will spend at least as much as what was spent in Federal Fiscal Year 2000 on services to elders residing in rural areas.

Poverty

- 1990 Census data showed that 10.4% of Vermonters age 75 or older lived at or below 100% of poverty. This level of detail is not yet available from the 2000 census.



- The 2000 Census data shows that 11.2% of Vermonters age 65 or older are living below the poverty level.
- Many elders' incomes are only slightly above the federal poverty level. According to a 2000 survey conducted by the Bureau of Labor Statistics, elderly households spent 33% of their annual incomes for housing, 16.6% of their income on transportation and 12.2% on health care.⁵ An analysis of spending between 1984-1997 found that spending by elder consumers increased significantly, by 14% – 18% and that spending for health care by elders comprised almost one third of all health care spending nationwide, with notable increases in spending for health insurance and drugs. These expenses bring many close to or below the federally defined poverty threshold.⁶
- The risk of poverty is strongly related to marital status. Those who are unmarried are more likely to be poor. This is particularly true for elder women, who if unmarried are four times as likely to be poor than their married counterparts.⁷

Minority Elderly

- Vermont continues to have one of the lowest percentages of minority elderly in the nation, according to the 2000 Census. It represents a mere 1.7 percent of the total population age 60 or older.
- The 2000 Census reports 1,738 people were identified as age 60 or older and members of a minority group, which represents a 149% increase from the 492 elders reported in the 1990 census. Of these, 28% were 75 years or older. However, the Census minority data from 1990 – 2000 may not be directly comparable because of changes in the survey questions regarding race.
- The greatest proportion of the minority population can be found in Chittenden County. Of the state's 19,619 minority population, 7,125, or 36.3% reside in Chittenden County. 26.2% of elder minorities (456) reside in Chittenden County.
- 195 Vermont elders were identified in the 2000 Census as Native Americans. This comprises only 0.2% of elders age 60 and older in Vermont. According to the 1999 Population and Housing Estimates published by the Vermont Department of Health, the highest concentration of people who identified themselves as Native Americans can be found in Franklin County.⁸
- Vermont's Abenaki population does not receive tribal aid because they lack federal designation as Native Americans. This increases the risk that older Abenakis, compared to other minorities, are likely to live at or below poverty.⁹

Health Care Issues

Recognizing that Vermont's elder population is projected to grow significantly in the coming years due to the aging of the baby boom generation and to increased life span of the population, the Department embarked on a new initiative in 2000. Much of the impetus for this effort came from the work and advocacy of the Area Agencies on Aging and the Community of Vermont Elders (COVE). The Successful Aging and Independent Living (SAIL) Initiative is designed to identify key areas of health and well being for the State's older population, to track changes in key indicators over time and to develop and promote activities for elders and adults with disabilities to stay healthy, active and to contribute to their communities. To achieve these goals, the Department convened a task force to support and give input on the Department's efforts to promote successful aging and independent living. As part of this process, four broad outcomes to describe successful aging and independent living have been established:

1. Older Vermonters have a low risk of disease and disease-related disability.
2. Older Vermonters maintain high physical and mental function.
3. Older Vermonters are as engaged in life as they prefer.
4. Older Vermonters live with dignity and independence.

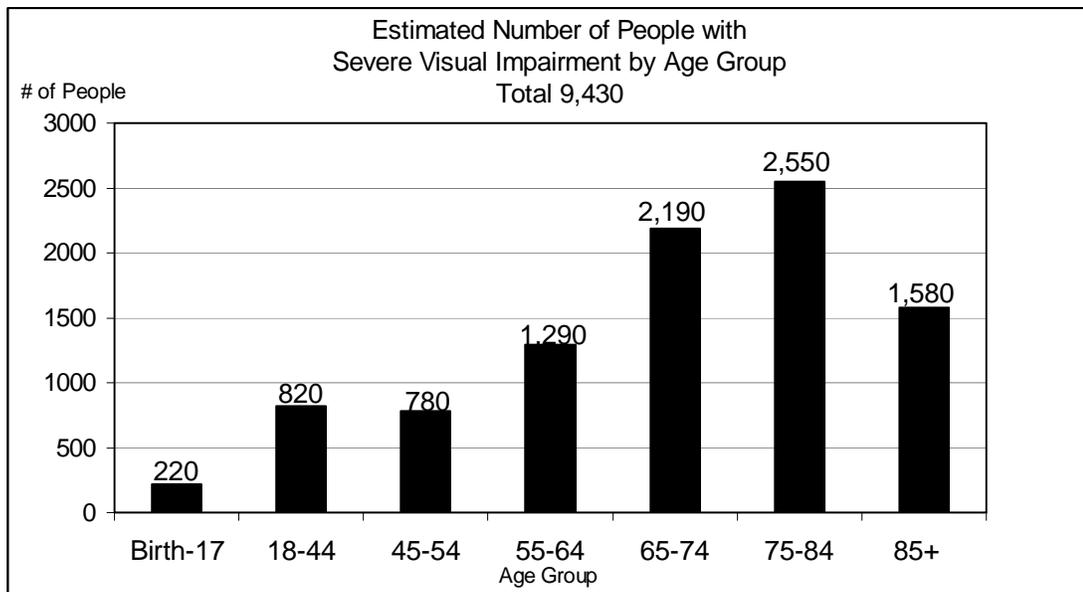
For more information about the SAIL Initiative and the work of the task force see the discussion of Health Promotion and Disease Prevention on pages 39 – 41 of the State Plan. The following discussion and information related to health care issues is closely connected with the SAIL Initiative. It is also important to note the role that local community hospitals and health centers play in meeting the prevention and successful aging needs, both physical and mental, of Vermont's elders. In many instances, these organizations often lead and coordinate local efforts to encourage successful aging and independent living.

Indicators of Health and Disability Status

- The average lifespan of Vermonters is increasing. The average life span for a woman is 80, for a man, it is 74. Although recent national surveys show a reduction in disability in the elderly population¹⁰, the elderly population is at greater risk for arthritis, osteoporosis and other physical disabilities.¹¹
- According to the Vermont Department of Health, although more non-institutionalized elder Vermonters have been vaccinated than the national average, pneumonia and influenza are the leading reason for hospitalization among Vermonters over age 65. Each year, 150 to 200 Vermonters die of these diseases.¹²
- Information compiled in the Vermont SAIL 2001 Legislative Report notes that over 60 percent of elders who participated in a Vermont survey were overweight or obese and that fewer than 20 percent of overweight elders were advised by a physician to lose weight.¹³
- Although regular physical activity is known to have many health benefits such as increased strength and stamina and decreased risk of disease and depression, only 23% of elders who participated in the Vermont survey reported that they exercise at least 5 days per week for at least 30 minutes.¹⁴
- Advanced age correlates highly with the need for hospitalization. More than half (56%) of Vermont's hospital costs were paid by Medicare in FY '95. According to the Vermont Agency of Human Services, more than half of the days of care provided by Vermont hospitals in 1999 were for people over age 65. The average length of stay in a hospital for Vermont elders was 5.9 days, compared to 4.2 for persons under age 65.¹⁵
- The two leading causes of death for Vermont elders are heart disease and cancer. These are followed by chronic obstructive pulmonary disease (COPD), strokes and diabetes.¹⁶
- Arthritis, osteoporosis, incontinence, vision and hearing impairments, Alzheimer's Disease and related dementias remain the most common chronic health conditions related to aging.¹⁷
- Diabetes ranks fifth as the cause of death among older Vermont residents and is the major cause of limb amputations, blindness and kidney disease, yet is one of the most "treatable" of chronic conditions if appropriate preventive and intervention measures are taken.¹⁸
- Falls are by far the leading cause of injury-related hospitalizations and in Vermont the hospital costs for treating falls (\$19.5 million between 1998 -

1999) exceeded the costs for treating the next 6 leading causes of injury-related hospitalizations combined. For elders, the risk of falls is particularly grave, as the most common cause of injury and comprising 87% of all fractures.¹⁹

- Hip fractures resulting from falls are especially dangerous for elders, particularly women who account for 75 - 80% of all hip fractures. Hospital stays for hip fractures average about 2 weeks; and it is estimated that half of all elders are unable to return home or remain independent after a fall that results in a hip fracture.²⁰
- In fiscal year 2001, 11% (874) of the 8,163 people participating in congregate meals and 24% (955) of the 3,902 participants who received home-delivered meals were assessed to be at high nutritional risk.²¹
- According to the 1990 census, visual impairment frequently leads to loss of independence, both in the home and in the community. Vision loss is the third ranked disabling condition for elders nationally²² and it is estimated that 1 out of every 6 elders experiences some degree of vision loss.²³ Of all Vermont residents with a severe visual impairment 67% are over the age of 65.



- According to a 1997 National Nursing Home Survey conducted by the National Center for Health Statistics, approximately 26% of all nursing home residents had some level of visual impairment. 3% of residents were reported to have completely lost their sight, about 6 % were reported as “severely visually impaired” and over 16% were reported as "partially visually impaired."²⁴
- Cost and access to prescription drugs is a growing problem nationally and in Vermont. More drugs are being prescribed, including more expensive drugs, and increasing drug costs contributed to the 19% increase in retail drug spending between 1999-2000 alone. In addition, it is estimated that as many

as half of all Medicare beneficiaries are without prescription drug coverage. Beneficiaries with incomes between 175% - 200% of poverty spend the greatest amount out-of-pocket, with average costs of \$760 for those without any prescription coverage. Many elders choose to not fill prescriptions, or to not fill as many, resulting in deteriorating health and overall well being.²⁵

²⁶At the same time, the pharmacy industry maintained its stronghold among the Fortune 500, ranking number one in return on revenues (18.5%) and number one in return on assets (16.3%).²⁷

- Vermont elders follow a similar trend in accessing affordable prescription drugs. The 2001 SAIL Legislative Report finds that 28% of elders did not have prescription coverage, that those with lower incomes are most affected, and that 50% of elders paid \$1 - \$100 per month in out-of-pocket expenses on prescription drugs and an additional 14% spent over \$100 per month.²⁸

Mental Health and Substance Abuse

- The U.S. Surgeon General predicts that because of the expected growth in the older population, disability due to mental illness in elders will become a major public health problem in the near future. Dementia, depression and schizophrenia will pose particular challenges.²⁹
- Unrecognized and untreated depression in those over 65 remains a significant problem. According to the U.S. Surgeon General's Report on Mental Health, 8 to 20 percent of older adults living in the community and 37 percent of those in primary care settings experience symptoms of depression. In nursing homes, it is estimated that major depression increases the likelihood of mortality by 59 percent, independent of any physical health issues.³⁰
- Major depression is a predictor of suicide in older adults and, in elder white males, suicide occurs at a rate six times that of the general population. The highest rate of suicide is for white men ages 85 and older. Often, depression occurs with other medical illnesses so that health care providers often assume that depression is a normal response to the other illness. Studies show that many elders who commit suicide have visited a primary care physician within a very short time of the suicide; 20 percent on the same day, 40 percent within one week and 70 percent within one month.³¹
- In Vermont, males 65 years of age or older have the highest rate of suicide, occurring at a rate of 22 for every 100,000 individuals. This compares to a national rate of 18.36 per 100,000 individuals.³² Risk factors for suicide in elders are different than those for younger persons and include depression, chronic medical conditions, lack of social supports and divorce or widowhood, all common experiences for many elders who live alone, in impoverished circumstances.³³
- Although schizophrenia affects a very small proportion of the elder population (0.6%), the cost of mental health treatment is significantly higher than for other mental illnesses.³⁴
- The Center for Substance Abuse Treatment reports that the nation's elders primarily experience problems related to the abuse or misuse of alcohol and/or

prescription drugs. Nationally, the prevalence of heavy drinking in the age 60 and over age group is estimated at anywhere from 3 - 25%; and from 2.2 – 9.6% for alcohol abuse.³⁵

- Alcohol abuse in elders is often undetected, sometimes mistaken for other diseases or due to the tendency for clinicians to associate an elder with a parent or grandparent. The Center cites ageism, lack of awareness of the problem, clinician behavior and medical and psychiatric comorbidity as the key barriers to treating elders with substance abuse problems.³⁶
- According to the Coalition on Substance Abuse and Older Vermonters, 17% of elders are at risk for alcohol and prescription drug misuse. In Vermont, this translates to over 17,000 elders at risk. In 1999, 45 Vermont elders received substance abuse treatment in mixed age settings. In 2000, 142 elders received treatment, more than triple the number treated in 1999. The Coalition also reports that nationally, 21% of elders who are hospitalized have a diagnosis of alcoholism, with related costs as high as \$60 billion.³⁷

Cognitive Impairments

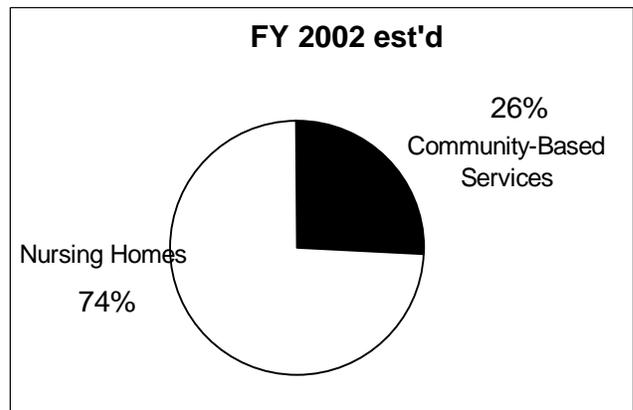
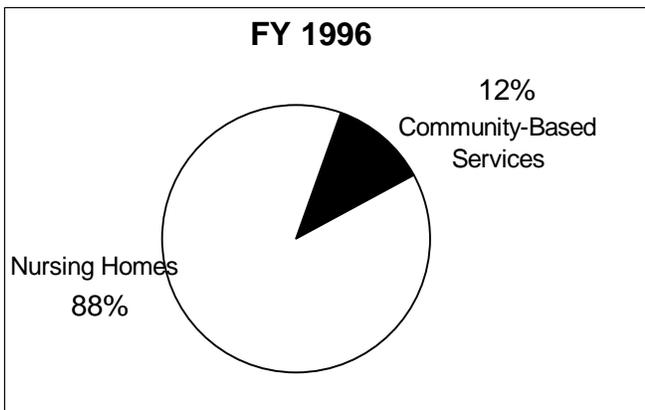
- The Vermont Chapter of the Alzheimer's Association reports that nationally one in ten people over age 64 and nearly half of those over age 85 have Alzheimer's Disease. It is estimated that 14 million baby boomers will develop Alzheimer's if no cure or prevention is found in the next 4 decades, a 10 million increase from today.³⁸
- In Vermont, there are an estimated 10,040 Vermonters with Alzheimer's Disease. Although 70% of those with Alzheimer's Disease live at home and families provide 75% of their care, national Medicaid expenditures are expected to increase 80% from 2000 to 2010, from \$18.2 billion to \$33 billion.³⁹
- The incidence of Alzheimer's Disease and related disorders continues to grow. According to the National Alzheimer's Association, approximately 4 million Americans have Alzheimer's Disease. This number is projected to reach 14 million by the middle of the century. Ten percent of persons age 65 and nearly fifty percent of those over age 85 have Alzheimer's Disease.⁴⁰
- According to the Governor's Commission on Alzheimer's Disease and Related Disorders, fewer than 50% of the estimated 10,040 Vermonters with Alzheimer's Disease have been diagnosed and only about 25% of this group receives any treatment or support services to help them cope with the disease. This implies that a significant percentage of older individuals may be at risk for improper treatment or lack of medical/social interventions and support.⁴¹
- The vast majority of Vermonters with Alzheimer's Disease or a related disorder reside at home and rely on informal systems of long-term care to do so. According to national data, the average annual at-home cost of care for an individual with Alzheimer's disease is \$12,500, compared to an average annual cost of \$47,000 for nursing home care.⁴² In Vermont, the average annual Medicaid reimbursement for nursing home care is \$50,000 and the estimated annual cost for those who pay privately is \$60,000.

- The average lifetime cost of the disease is \$174,000 and the majority of this cost is borne by families. Although there has been some recent clarification in Medicare coverage for some services provided to those with Alzheimer's Disease and related dementia, there remains a large gap in insurance coverage for the care and services specifically related to this illness.⁴³
- The U.S. Surgeon General reports that Alzheimer's Disease, especially when accompanied by behavioral symptoms such as delusions, hallucinations and depression, appear to place individuals at risk for abuse.⁴⁴

Nursing Home Occupancy and Utilization⁴⁵

- As of May 2002, there were 45 nursing homes with 3615 licensed beds.
- Most nursing home residents are 65 years of age or older.
- While 4% of Vermont residents over the age of 65 are likely to live in a nursing care facility, the prospect increases with age, to approximately 16% by age 85.
- While many people live in nursing homes, there are also many who receive nursing facility services for shorter stays as nursing homes continue to expand their ability to provide both inpatient and outpatient (for prior residents) rehabilitative services, respite and palliative care.
- In 2001, the leading reasons for admission to a nursing home were to receive short-term rehabilitation or skilled care (51.3%) and/or case needs related to a significant change in functional status (37.15%).
- There is a 43% risk of a future nursing home stay or placement for those age 65 years or older. This includes short-term rehabilitative stays.
- In SFY 2002, an estimated 74% of public expenditures for long-term care will be spent on nursing home care compared to 26% for home and community-based services. The impact of Act 160 is clearly evident when comparing these figures to the breakdown in 1996, before the implementation of the Act. At that time, an estimated 88% of public expenditures for long-term care were spent on nursing home care compared to only 12% for home and community based services.

Public Expenditures for Long Term Care

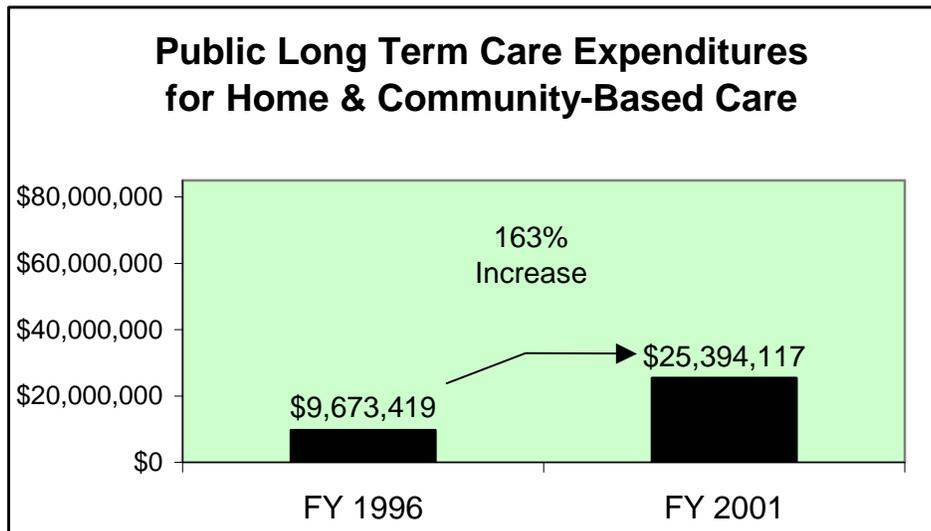
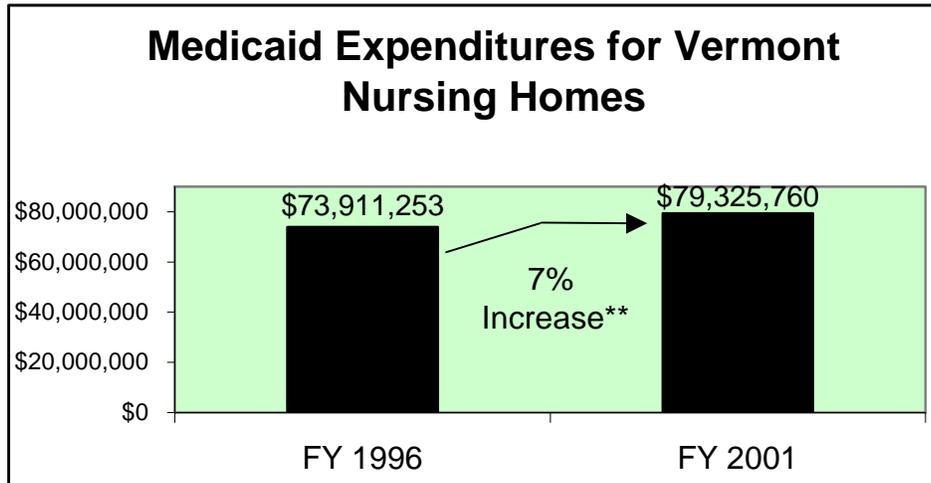


Family Caregiving

Family caregivers are in many ways the unsung heroes of long-term care, giving, and giving up so much; and receiving little in return, beyond the personal satisfaction they feel from caregiving. One of the most exciting developments in the field of aging in recent times occurred in 2001, with the implementation of the National Family Caregiver Support Program (NFCSP) as a new program under the Older Americans Act. Now, finally, new resources are available to recognize the contributions of family caregivers and to encourage continued caregiving by providing multifaceted systems of support services, specifically focused on meeting the needs of caregivers. To learn more about Vermont's NFCSP activities, please see pp. 41 - 42 of this plan. While we are still very much in the information gathering stage in Vermont, some of what is known about family caregiving nationally is discussed below.

- Nearly one out of every four households is involved in caregiving to adults age 50 and older. As the elder population continues to grow, so will the number of elders who rely on family and friends for care. In fact, the number of elders who have long-term care needs is expected to double from the current 7 million to 14 million by 2040.⁴⁶
- An important National Family Caregiving study in 1997 estimates that there are 25.8 million caregivers who provide an average of 17.9 hours of care on a weekly basis.⁴⁷ Over the course of a year, it is estimated that family caregivers contribute 24 billion hours of care.⁴⁸
- Based on the estimated number of family caregivers and hours of care provided, the estimated economic value of family caregiving in 1997 was \$196 billion. This figure far surpasses the value of formal home care (\$32 billion) and nursing home care (\$83 billion) combined.⁴⁹
- The average caregiver is a married woman in her 40's with a median annual income of \$35,000. Nearly two thirds of all caregivers are employed, many full-time, and 41% also have children under age 18 living in their homes.⁵⁰
- Older caregivers make up a significant proportion of caregivers nationally. 26% of all caregivers are between the ages of 50 – 64 and 12.4% are age 65 and older. The national study also found that older caregivers tend to be caregivers for those requiring higher levels of care, are more likely to be married to the person they are caring for and report a greater negative impact on their own physical and emotional health.⁵¹
- It is estimated that over 5 million households are caring for someone who has Alzheimer's Disease; and the challenge of providing care is formidable. Alzheimer caregivers are found to spend significantly more time each week (40 hours) than the average caregiver (17.9 hours), have been providing care for more than 5 years and are providing more intense levels of care. Alzheimer caregivers are also more likely to report physical, emotional, family and financial strains than other caregivers.⁵²
- Recent estimates indicate that grandparents are living with and are the primary caregiver to close to 4 million grandchildren in the United States.⁵³

Shift the Balance



Independent Living and Community Based Services

A Snapshot of Expanding Needs

- For many Vermont elders, the state's 158 professional senior centers and meal sites play an important role in promoting successful aging and independent living. Nutritious meals are just one of the services offered at these locations. Over time, many centers have expanded to provide transportation, educational, health and recreational programs. They offer an important opportunity to socialize and maintain connections with the local community; and provide support and reassurance to family caregivers in need of information and respite.

- With the expansion of Medicaid Waiver funded services to 1050 slots statewide, nursing home occupancy continues to decline. In June of 2001, nursing home occupancy dropped to an all time low of 88.14%. Presently, the nursing home occupancy rate is 89.83% compared to 91.5% at the time the last State Plan was written in 1997. However, when taking into consideration the fact that over 200 nursing home beds have closed since the implementation of Act 160 in 1996, the adjusted nursing home occupancy rate is closer to 86%.
- Demand for Home and Community Based Medicaid Waiver services continues to increase. Currently, the Department's Medicaid HCBS Waiver serves only those people who have the greatest needs and are at greatest risk. The demand for Medicaid Waiver services continues to exceed the available supply.
- The Department's approach to "shifting the balance" between nursing facility and home and community based expenditures is showing results. Between the years 1997 and 2002, total public expenditures in the Department's Medicaid HCBS Waivers grew by 353%, and the number of people served grew by 185%.⁵⁴ 83% of the people served by the Department's home-based waiver in State Fiscal Year (SFY) 2001 were over the age of 60, and had an average age of 74. 98% of the people served by the Department's Enhanced Residential Care Waiver in SFY 2001 were over the age of 60, and had an average age of 83. In contrast, between 1996 and 2001, Medicaid expenditures in nursing facilities grew by only 7%.
- According to the Vermont Assembly of Home Health Agencies (VAHHA), Vermont's 13 home care agencies served fewer people, employed fewer full-time equivalent (FTE) caregivers and the number of home care visits decreased between 1999 and 2000. The number of people served declined from 23,620 to 21,726, an 8% decrease. Home care visits declined 6.2%, from 982,157 to 920,906. Home Health Aide visits saw the greatest decline, down 13.5%, from 373,673 to 323,022. According to VAHHA, these decreases are due to the more restrictive Medicare eligibility requirements and changes in the Medicare reimbursement from fee-for-service to a new Interim Payment System.⁵⁵
- The five Area Agencies on Aging report an increasing demand for home-delivered meals services. In Federal Fiscal Year (FFY) 2001 the AAAs provided 574,910 meals, nearly a 26% increase from the FFY 97 level of 456,380. As more of the 'old-old' population ages in place, we anticipate an increase in the population of Vermont elders who will need to access this service.
- In FFY 2001 the five AAAs provided case management to 8,160 individuals who needed more than Information & Assistance or brief contact assistance. This represents a 6.7% increase from FFY 1997.
- From SFY 1998 to SFY 2001, participation at the state's adult day centers increased 18%, from 718 to 877 and the overall units of service increased 99.23% from 184,874 to 368,328.

Transportation

- Transportation, whether provided by the elder driver, provided by family and friends, or through public transportation or other services, is a key factor in elders' ability to access needed health care and other services, to participate in their communities and families and to maintain their independence and well-being.
- Elders strongly prefer and depend heavily on private vehicles for their transportation. This is particularly true for those living in more rural areas, where people need to travel farther distances to access services and where there is a lack of public transportation.⁵⁶ Nationally, elders make over 90% of their trips in private vehicles and tend to travel fewer miles than the general population. A recent report by AARP notes that 74% of elders (age 65+) are licensed drivers.⁵⁷
- The proportion of licensed drivers and the miles traveled decreases with age. In addition, those who experience poor health and/or disability are more likely to experience difficulty in mobility.⁵⁸ This increases the likelihood of isolation and inability to access services, visit friends and participate in community life. In our predominantly rural state with its shortage of public transportation assistance, many older Vermonters keenly feel this reality.
- In Vermont, private vehicles are the primary means of transportation, with more than 98% of all travelers riding in private vehicles on any given day. The Vermont Agency of Transportation (VTrans) estimates that the average “vehicle miles” traveled has increased from 32 in 1995 to 36 in 2001.⁵⁹
- Approximately 61% of Vermont’s elder population are licensed drivers and own a registered vehicle.⁶⁰
- Much concern has been raised regarding public safety and older drivers. In fact, older drivers are not a major threat to public safety. Older drivers travel fewer miles and have the lowest rate of car crashes than any other segment of the population. They tend to reduce the risks they take when they drive, such as only driving during daylight hours, using restraints and avoiding busy streets.⁶¹
- However, the mortality rate for older persons, whether driving on their own or as a passenger, is greater. This is attributed to the increased frailty that occurs with age and environmental factors that affect one’s ability to drive. At the same time, it has not been proven that state policies that place limits or restrictions on driving have any impact on safety. Instead, experts recommend improving driver assessment, treatment and training and making improvements to vehicles and the driving environment in order to improve safety.⁶²
- Of the 79 persons killed in motor vehicle crashes in Vermont in 2000, 22% (17) of the victims were age 55 and older and 15% (12) were 65 and older.⁶³
- For those who no longer drive and who do not have ready transportation assistance from family or friends, public transportation is extremely important. In 2000, Vermont’s Public Transportation system was projected to top 3 million one-way trips for the first time in the history of the program.

And yet, it is difficult to provide public transportation in a rural state such as Vermont because there may not be a high enough volume of people traveling to or from the same locations to make fixed route service efficient and affordable. Instead, Vermont's public transportation providers are challenged to design and develop creative solutions to meet the needs in rural communities, such as demand response services or route deviation services.⁶⁴

- In addition to needing adequate amounts and creatively designed public transportation, it may be necessary to offer special training to elders who have never used public transportation. Transportation providers also need training regarding the special needs of elders and need clear guidelines for making reasonable accommodations if elders and people with disabilities are to be able to use their services successfully.
- AAAs provide much needed support to elder transportation and invest a lot of effort into working with the transportation providers in each region of the state. However, the increasing demand for transportation means that some AAAs have had to develop new methods to manage their transportation resources. Some AAAs have had to limit the number of trips an individual may receive or amount of money that can be spent, have prioritized the transportation based on the purpose of the trip and have increased the coordination of trips to and from a given region. For example, instead of providing multiple individual rides, people from the same town plan trips and ride together on a specified day of the month.

Living Arrangements

- As is the case nationally, close to 96% of Vermonters age 65 or older live in home and community based settings, rather than in a nursing care facility.⁶⁵
- In Vermont, 84% of individuals age 85 or older live in home and community based settings.⁶⁶
- According to national statistics the majority of older persons live with a spouse and/or family. The latest census figures show that 83 % of older men and 60 % of older women live with others.⁶⁷
- Almost half of all older women are widowed (45%), compared to men who are much less likely to be widowed (14%).⁶⁸
- Nationally in 1997, 633,000 grandparents age 65 and older maintained households in which grandchildren were present and an additional 510,000 lived with their grandchildren in parent-maintained households.⁶⁹ As part of our work with the NFCSP in Vermont, we are in the process of gathering information related to the number of households in which grandparents and grandchildren are living together.
- Nearly 82% of Vermont elders reside in rural communities. Of these elders, a significant percentage lives outside of even small village settings. Many are no longer able to drive and have limited or no access to public transportation assistance, which increases risk factors associated with aging, including isolation and lack of access to essential services.

Residential Care Homes⁷⁰

- Vermont's residential care homes offer a less restrictive living environment than nursing home care, in a community based setting. There is great diversity among Vermont's providers with a range of options in setting, size and types of services. The 88 Level III facilities offer 24-hour on-site staffing.
- As of May 2002, there were 110 Level III and IV residential care facilities in the state, with 2,287 licensed beds. This represents a decrease of 14 licensed facilities, but an increase of 74 beds as compared to the 1999 State Plan. The two primary reasons that homes have closed is due to the retirement of the operators of the home and the pressure of financial issues.
- Occupancy for residential care homes has averaged between 80 – 85%; however, there is noticeable variation in the occupancy from home to home.
- In 1993, the median age of residential care home residents was 81, comprising about one third of the total residential care home population. Recent figures for the Enhanced Residential Care (ERC) Medicaid Waiver program show that the average age of participants in this program is 83, compared to an average age of 74 in the Home Based Medicaid Waiver program.
- 38 licensed Level III residential care homes, or 30 percent, are Enhanced Residential Care (ERC) providers participating in Vermont's newest Medicaid Waiver program. Since its inception in 1996, the ERC waiver program has grown to serve nearly 200 people per year.
- In SFY 2000, the new Assistive Community Care Services (ACCS) was implemented. ACCS is a Medicaid State Plan program in which Medicaid pays for certain care services provided in approved Level III residential care homes to residents who are eligible for Medicaid and need the services. This program has increased the reimbursement to Level III residential care homes for certain low-income residents (those at the Supplemental Security Income, or SSI level) by bringing additional revenue necessary to help stabilize the residential care home industry. This allows providers to increase the number of low-income residents served. Since the program first began in July 1999, the number of providers enrolled in the program has increased from 67 to 74 in 2001, a 10.4% increase. In the first year of operation, the program provided ACCS to 544 low-income residential care home residents and grew to 669 in the second year; nearly a 30% increase.

Volunteer Opportunities to Support Successful Aging and Independent Living⁷¹

- A strong correlation exists between maintaining one's health and well being and remaining active and involved in one's community.
- Several thousand Vermont elders contribute to their communities each year through volunteer work with programs such as the Foster Grandparents Program, the Neighbor-to-Neighbor Americorps Program, RSVP and the Senior Companion Program.
- According to a 2001 Foster Grandparents survey of 45 participating elders, 94% stated that volunteering for the program gave them a reason to get up in

the morning, 94% said it gave them a sense of purpose to their life, 92% experienced increased self-esteem and 89% indicated that it made them happy.

- In FY 2001, the Foster Grandparent Program's 144 volunteers served 2,282 children in 58 agencies and provided 105,368 hours of service throughout the state, at an estimated value of \$1,464,615.
- In FY 2001, 3,939 RSVP volunteers served in 884 agencies and provided 408,567 hours of service across the state, an estimated value of \$5,679,081.
- At the same time, 85 Vermont Senior Companions spent 63,700 hours providing supervision and support, assistance with a range of daily tasks and light housekeeping to 585 Vermont elders in order to help them remain independent, and at an estimated value of \$885,430.
- Although you don't have to be an elder to volunteer, the Neighbor-to-Neighbor Americorps Program provides essential support to Vermont elders and adults with disabilities to enable them to remain at home. In FY 2001, 1,300 volunteers provided assistance to 1,500 elders and adults with disabilities, providing 9,400 hours of service.

Employment

- "Retirement" has taken on new meaning for the Baby Boom generation. Many of today's Baby Boomers intend to maintain active lifestyles after they reach the historical age of retirement. Volunteer and work opportunities will be an area of increasing interest for Vermont. In fact, almost 64% of Vermont's Aging Boomers (aged 50 – 59) report that they plan to remain in the labor market after retirement. While the most common reason cited for continuing to work was because "I enjoy what I do and want to stay involved," significant numbers of Vermont's Aging Boomers also plan to work in order to retain health care benefits (77%) and to make ends meet financially (64%).⁷²
- AARP reports that since 1985, national labor force participation by older workers continues to rise at a steady pace. From 2000 to 2001, labor force participation rose from 32.3% to 33.1%. At the same time, however, the average unemployment rate for elders rose from 2.6% in 2000 to 3% in 2001. This compares to a 4.8% unemployment rate in the general population in 2001.⁷³
- In the Older Americans Community Service Employment Program (OASCEP), 152 participants age 55 and older were placed at public and private non-profit organizations and provide 62,4000 hours of service at an estimated value of \$390,000. Of this number, 32 participants moved into unsubsidized placement.⁷⁴

NEEDS, ISSUES AND CONCERNS OF OLDER VERMONTERS

Much has been accomplished in the past several years finding new resources and expanding the choices and options available for elders to live as independently as possible and to remain active and contributing members of their communities. Though progress has been made, much more remains to be accomplished. The challenge will be even greater today as we strive to achieve results in the face of a shrinking state economy and when the entire country is understandably focused on preserving safety and security during this time of national turbulence. So, as the population of Vermont elders increases many of the concerns outlined below will become even more significant. We anticipate a corresponding increase in demands placed upon the service delivery systems as well as a need to become more creative in meeting the needs of the aging population. Vermont has an advantage in that it is a small state, both geographically and population-wise. Therefore, we are able to maintain regular communication and work closely with individual consumers, our advisory groups, the Community of Vermont Elders (COVE) consumer groups, state agencies, the AAAs and our other community partners. These are the issues and concerns that we hear, in meetings, focus groups, at conferences and through the surveys we conduct. Regardless of which group we hear from, several consistent themes emerge.

The most frequently expressed areas of concern include:

Consumer Direction and Independent Living

- Frequently elders and/or their families struggle to identify and find resources to meet their particular needs. In a series of focus groups held in 2001, the demand for a single, comprehensive statewide source of information and assistance (I&A) was identified as an important need. People want services to be clearly defined and to have information provided in "plain English, " using non-technical language and easy to follow. In addition, while focus group participants expressed that a toll-free number and a web site are the preferred vehicles for accessing information, they were also adamant about the importance of having access to a knowledgeable person to speak with when dealing with a crisis situation.⁷⁵ In FFY 2001, the five AAAs received 22,027 requests for assistance through the Statewide Senior HelpLine, representing an increase of more than 52% in I&A requests compared to FFY 1997.
- The desire to age in place, to develop residential alternatives and to prevent premature nursing home placement is of key interest to elders in Vermont. We have been working hard to develop new models, identify new resources and expand the capacity for elders to remain in their communities with a variety of residential supports. Still, need outstrips demand and more work must be done to give consumers new and expanded choices and to have sufficient capacity to meet the need statewide. The lack of senior independent housing for some income groups, the need for improvements in design

practice to assure accessibility and the challenges small communities face in developing and managing small scale, local projects are of particular concern.

- According to a 2001 survey, while consumers of the State's community-based long-term care services were well satisfied with the quality of services provided, they were noticeably less satisfied with the amount of choice and control they had when planning their services.⁷⁶ Elders clearly want to have a sense of control over their own lives and want to make their own decisions.
- When it comes to deciding which services to choose, elders want to know that there are resources available and that there is a coordinated system of services, which is easy to understand and navigate.
- Access to public transportation, and for some, assisted transportation, plays a large role in whether one remains independent. Losing one's license is a great concern to many older individuals. Coupled with the inability to access public transportation services, an elder's independence and self-esteem may be seriously threatened. Loss of ability to "get around" may become a determining factor in whether one can successfully "age in place."
- Social isolation, related to loss of contact with family, friends and the larger community/society is a key concern. Vermont's long-term care consumers are less satisfied with the amount of socialization and connections to their community, are less satisfied with the amount of contact they have with family and friends and are less likely to feel valued and respected than the general public.⁷⁷
- For many, Vermont's senior centers can play an important role in helping to maintain connections with the community and general well-being, but many centers are struggling to stay open in the face of mounting financial pressures.
- For many older Vermonters, having the means to maintain one's own home is key to remaining independent. High property taxes, home maintenance costs, cost of home heating fuel and related home ownership expenses impose heavy burdens on many who struggle to retain an independent life style.
- There is an increasing interest in understanding better the special needs of grandparents and other elder family members who are caring for children and finding ways to support grandparents to maintain their connection with children.

Health Care

- Vermonters continue to wait and work for substantive improvements in affordable, accessible coverage for health care, including adequate coverage for long-term care services and prescription drugs.
- Concerns about rising prescription drug costs and lack of insurance coverage for these costs tops the list of concerns for many Vermont elders. COVE and the AAAs have been leaders in providing information and developing resources to improve access and address these concerns. However, Vermont elders are vocal about the need for real reform of the pharmaceutical industry coupled with affordable and accessible prescription drug coverage.

- Restrictive language related to definitions of ‘medical necessity’, ‘homebound’ and ‘skilled’ services have already had a negative impact on older Vermonters who rely on home care services to help them remain at home. Although some improvements have been made to allow Medicare beneficiaries to receive adult day services without jeopardizing their homebound status, many beneficiaries remain essentially "prisoners in their own homes," unable to leave to participate in their community for fear of losing their Medicare coverage.
- Significant expenditures for health care services, including increases in Medigap premiums, are of great concern. In Vermont, elders are limited in the insurance choices available and have no Medicare + Choice plans available. There is only one standard Medigap plan that includes prescription coverage; and it is unaffordable for many Vermont elders.
- Although Act 160 and the SAIL Initiative have greatly expanded health promotion and disease prevention, access to prevention type programs (education, self-care, etc.) continues to be limited. Elders, family caregivers and the general public are thirsty for more information about the long-term benefits of a healthy lifestyle and want more preventive activities to promote their individual efforts.
- The lack of coverage for eyeglasses and hearing aides and the insufficient funding available to purchase dentures and dental care create significant problems for many elders. These health aides can serve as essential tools for the prevention of problems such as malnutrition, communication difficulties, loss of independence and life-threatening falls. Although coverage for eyeglasses under Medicaid will be suspended from July 1, 2002 – June 30, 2003, Medicaid does provide some coverage for analog hearing aids, dentures and dental care.⁷⁸ Still, there are many elders who do not qualify for Medicaid assistance and experience gaps in other health insurance coverage.
- Personal care attendants and licensed nurse's aides are in short supply. The problem is exacerbated by increasing demand for the services, low wages and poor or non-existent benefits. Staff shortages and the frustration felt especially by nursing home caregivers who had insufficient time to provide quality care create additional barriers to recruiting and retaining people to provide these important services.⁷⁹

Long Term Care

- Shortage of available and well-trained caregivers is an ongoing problem, and is critical to supporting long-term care in home-based settings. There is an increasing need for home care providers who can offer nighttime and/or weekend respite care and an apparent shortage of caregivers to provide this type of assistance. Nursing facilities and residential care homes also report significant staffing shortages.
- The importance of supporting and encouraging family caregivers, including the need to provide them with information they need to hire and manage paid caregivers, is noted by advocates and family caregivers themselves.

- Impoverishment associated with long-term care and institutionalization is of great concern. While Medicare provides coverage for many medical needs, it is not designed to cover the costs of long-term care. Private insurance for long-term care remains unaffordable for most elders. Elders and family caregivers want factual information and help accessing the full range of long term care options and how to pay for them.
- Loss of one's independent status and the desire to receive long-term care services and remain at home is one of the most frequently cited concerns among older individuals.⁸⁰

Economic Security

- Like much of the country, Vermont's economy has become unstable and we are facing a serious budget shortfall. So far, we have been able to avoid potentially negative cuts in services due to savings in the nursing home Medicaid budget. However, in the face of the budget shortfalls, our ability to grow home and community-based services will be severely limited and creative methods must be found to continue our efforts to develop and expand community resources and to continue to "shift the balance." Especially in these uncertain financial times, elders living on fixed incomes continue to worry about the affordability of health care costs
- Uncertainties about the future of Social Security, Medicare, health insurance and private pensions are of great concern to most elders. As the stock market continues to be volatile, the nation's elders grow increasingly concerned about the security of their retirement investments and whether or not they will have enough money to cover their expenses. This will be an area of interest and concern in the months and years ahead.
- The ability to afford rising property taxes, in comparison to incomes, and to cover other costs associated with home ownership is a concern to many elders. Many elders live in older homes that are more difficult to modify for accessibility and are more expensive to heat and maintain. The problem is compounded for elders with decreased investment incomes.
- Even slight shifts in the cost of prescription drugs, health care, transportation and housing have a dramatic impact on those living on fixed incomes. A significant percentage of our older population struggle continually to make ends meet. As discussed earlier in the State Plan, retail drug spending increased 19% from 1999 – 2000, and elders pay a disproportionate amount of their personal income on prescription drugs, with average out-of-pocket costs of \$760 for people between 175-200% of poverty without any prescription coverage.

**GOALS, OBJECTIVES AND
PROGRAM RESOURCES
for
FFY 2003 TO 2005**

PLANNING for the FUTURE

In the State Plan for FFY 1999-2002 the Department identified six broad goals on which we would focus our efforts for that period. These remain viable and will continue to be an important focus for our work. Generally, we have reformulated some of the goals, consolidating and adding emphasis when necessary. To these we add an additional goal to plan for and implement activities designed to support family caregivers and to encourage them to maintain this important role in the community.

One of the particular challenges facing the Department and its grantees in planning for the future is that aside from the implementation of the National Family Caregiver Support Program, funding for the Older Americans Act has remained stagnant for a decade or more. The 7.7% increase in overall funding from the OAA this past year cannot begin to keep pace with inflation or the rapidly expanding numbers of older Vermonters and their service needs. Nor does it adequately provide the resources needed by the AAAs to keep pace with the information system technology changes necessary to do their work.

While the majority of benefit programs and services available to older individuals are funded by the federal and state government, there are many additional sources of support, ideas and inspiration which come from individuals, communities and community based organizations. In fact, some of the best ideas for preventive approaches have come from our communities. We look forward to working with the AAAs and their community partners, including the Long Term Care Coalitions, to identify innovative prevention programs that create new opportunities to support independent living initiatives for Vermont elders.

Goals, Outcome Measures and Objectives

The following broad goal statements and outcome measures are linked to the specific programs and strategies within the Resources Section. Each Goal Statement is applicable to one or more of the defined Resources, which incorporate the Department's current approaches and strategies. Within this section each identified Resource includes one or more identified Objective(s) for the 3-Year Plan period.

- 1. Enhance the ability of Vermont elders to live as independently as possible, actively participating in and contributing to their communities, by expanding the options available to consumers who choose not to live in an institutional setting, maximizing the value of public resources by targeting community-based and consumer-directed services to those with the greatest need, and by improving the efficiency and effectiveness of the services and service delivery systems.**

Outcome Measures:

- Results from the Consumer Perceptions Survey regarding the degree of consumer satisfaction with the quality of services.
 - Results from the Consumer Perceptions Survey regarding the degree of satisfaction with the amount of choice and control when planning services.
 - Expansion of individuals served and volume of services provided in Medicaid Waiver services, adult day, nutrition services, information and assistance services and case management.
 - Expansion of consumer-directed services in the Medicaid Waiver and Attendant Services Programs.
- 2. Continue to shift the focus of long-term care funding toward services that expand our capacity to promote and provide prevention-based systems of service.**

Outcome Measures:

- Results of the four broad outcomes for Successful Aging and Independent Living which will measure the elder population for: 1) low risk of disease and disease-related disability, 2) maintenance of high physical and mental function, 3) engagement with life; and 4) living with dignity and independence.
- 3. Continue the development and enhancement of multifaceted systems of services to provide needed support and resources for family caregivers, and which encourages them to maintain the caregiving role.**

Outcome Measures:

- The State is still in the process of designing a system to collect and analyze baseline data related to the number of family caregivers receiving services and the types of services provided. As this process develops, the Department will measure the number of caregivers served, the types of services provided and will include caregiver satisfaction with services in future consumer surveys.

- 4. Develop a system of continuous quality improvement that includes effective evaluations of those services and organizations funded under the Older Americans Act, as well as those linked to these services and organizations through the community network of providers.**

Outcome Measures:

- Evaluations of services and organizations funded under the OAA, and those linked through the network of community network of providers.
- Results from the Consumer Perceptions Survey regarding the degree of consumer satisfaction with the quality of services.
- Results from the Consumer Perceptions Survey regarding the degree of consumer satisfaction with the amount of choice and control when planning services.

- 5. Develop systems for tracking outcome based performance indicators related to the OAA and other programs, to ensure the efficient and effective use of funding for aging programs.**

Outcome Measures:

- Findings from the outcome measurements at the AAA and community level.
- Upon completion of the Administration on Aging Performance Outcome Measurement Project (POMP), the Department will measure the information gained.

- 6. Support the Long Term Care Coalitions in order to increase their capacity to plan for and meet the needs of the state's aging population.**

In addition, we will work closely with our community partners to monitor and evaluate the agreed upon indicators of well-being for aging Vermonters in order to track our success in achieving both short and long-term goals. As part of this initiative we will work to:

Objectives:

- Examine performance measures under development by the Administration on Aging (AoA).
- Identify performance measures currently in use by others in the aging network.
- Utilize the revised National Aging Programs Information System (NAPIS) as approved by the federal Office of Budget and Management.
- Gather information on best-practice approaches to performance measurement.
- Develop agreed upon performance outcome measures with the AAAs.
- Develop a means to track such measurements and report on findings.
- Implement improvements including activities, plans and programs designed to respond to key findings based on outcomes/measurement data.

RESOURCES

Human Resources

Vermont is proud of the many dedicated people working at all levels of the aging network. We are fortunate to have a large corps of highly qualified and committed individuals, many of whom have dedicated much of their adult life working to ensure that elders are able to live as independently as possible and to actively participate in their communities. Thousands of paid and volunteer staff are at work every day, providing personal care, delivering nutritious meals, driving elders to adult day centers, developing action plans to help an elder and their family caregiver develop a plan to stay at home and facilitating support groups.

As the demand for services continues to grow, so will the need for a stable, well-trained labor force. In 2000, the Department recognized the need for professional caregivers to provide care to a growing population and established a Staffing Study Steering Committee. The Committee was charged with developing recommendations for creating "a stable, valued, and adequately reimbursed workforce to provide quality care for individuals and families." In order to develop the recommendations, a study was commissioned to gather data about the demand for services, the labor force, recruitment and retention and best practices. The Steering Committee made a number of recommendations to expand the pool of possible caregivers, improve wages, provide benefits, improve working conditions and promote the professional development of caregivers.⁸¹ The work to carry out the recommendations has begun and will be an on-going effort.

In addition, Act 160 funds have been used to increase wages for professional caregivers in the consumer directed/surrogate directed Waiver options and the Attendant Services Program (ASP) and for case managers. Additional funds have been used to develop and provide training and technical assistance for a variety of aging network staff and to support other efforts that will ensure professional development and staff retention.

Funding

Older Americans Act funds make up only a portion of the financial resources available to meet the needs of the elder population in Vermont. As discussed earlier, the modest increase in funding has not kept pace with inflation, or the growing population. However, the reauthorization of the OAA did include new funding to provide support and services to family caregivers, which is a welcome new resource in Vermont.

While there will always be challenges in finding the resources to meet both short and long term goals, the Department is encouraged by the success of the past several years in implementing Act 160. The results of these efforts are clearly visible. We will continue to develop and expand home and community-based services and programs and attempt to identify innovative approaches, including those that focus on preventive services,

consumer directed services and maximizing flexibility to meet the needs of an expanding aging population.

The success of Act 160 and the momentum created as new initiatives begin will continue to drive much of the work of this Department, including activities undertaken by the AAAs and funded under the OAA. Even in the face of the present budget shortfall, we anticipate increased investments and dramatic restructuring in our community-based systems in the coming years. And, we expect that both the Department and our community partners will identify additional ways to collaborate with new partners and bring focus to expansion of capacity for current and future services.

Among the resources which are key to meeting the needs of elders, a number of cash benefit programs are administered by other departments of state government and local organizations. These resources include cash benefits, Food Stamps, fuel assistance, V-Script, Social Security, the Retired Senior Volunteer Programs, Foster Grandparents, the Senior Community Services Employment Program, etc.

Data

Collecting and analyzing data about the programs we administer and the people we serve is important to evaluating our success in meeting elders' needs and achieving our stated goals. It allows us to identify unmet needs and gaps in services and to plan for improvements to the available services and resources. Presently, the Department utilizes two databases, the Social Assistance and Management System (SAMS) and DAILCARE to manage the information related to the OAA and other funding sources. Data management is a rapidly developing field, with new software and resources being produced every year. In fact, we are planning to upgrade the SAMS database to the newest product SAMS 2000 and are working on the finishing touches of implementing a central server with interested AAAs to make the storage and management of information as efficient and affordable as possible. In addition, the new federal Health Insurance Portability and Accountability Act (HIPAA) includes new requirements regarding how information is stored, managed, safeguarded and shared. We are in the process of assessing changes necessary for compliance; and will be working with other state agencies and our community partners to implement the changes.

During 2001, the Department initiated a project to measure Vermonters' future needs for long term care and the system's capacity to meet those needs. With the assistance of a consultant, the Department has developed a model to project needs and capacity for the years 2005 and 2010, using 2000 as the baseline. This model will be periodically refined and updated in order to provide the Department with valuable information on an ongoing basis. Components of this model include such variables as the declining rate of elder disability and the reduced utilization of nursing homes, as well as current program participation. Results will be available in the fall of 2002.

Special Projects

The Department is fortunate to have many effective collaborative relationships with other state agencies and our community partners. Through our efforts, a number of special needs have been identified; and we have implemented special initiatives to address them.

Vermont's Real Choice Systems Change Grant: Vermont is embarking on an exciting systems change effort in a partnership that includes consumers, the Department of Aging and Disabilities and the Department of Development and Mental Health Services. This is a three-year project, funded with \$2 million from the Centers for Medicare and Medicaid Services (CMS).

The goal of Vermont's Real Choice Systems Change grant is to effect enduring system change that:

- Promotes continued progress toward community integration of services; and
- Provides real choices about how, where and by whom services are supports are delivered.

The objectives of the grant are to:

- Provide consumers with tools to exercise real choice – information, technical assistance and self-advocacy skills;
- Increase options for and access to community-based services for elders and younger persons with physical disabilities through the expansion of the existing 1115 waiver; and
- Increase consumer control through a direct funding option for consumers of developmental services.

To achieve our goal, we will concentrate our efforts in the following areas:

- **Information and Assistance:** Improve and coordinate mechanisms across systems to provide consumers with easy access to independent, consistent and accurate information, and assistance in navigating the service delivery system.
- **Self-Advocacy, Self-Determination and Recovery Education:** Identify best practices to foster self-determination, self-advocacy and recovery among consumers and develop methods for expanding the implementation and availability of those practices.
- **Workforce Development:** Create a valued, adequately reimbursed and well-trained workforce across the systems.
- **Expansion of the 1115 Waiver:** Expand Vermont's existing 1115 Waiver to provide real choices for consumers interested in home and community-based services and to eliminate the Medicaid bias toward nursing homes.
- **Direct Consumer Funding (Development Services):** Research the option and implement a pilot project for providing direct funding for supports and services to people with developmental disabilities and their families.

Vermont Disability and Health Promotion Project: Vermont's public health surveillance and activities have not focused on health promotion for people with disabilities. And, Vermont lacks the information required to design and implement effective public health activities to prevent secondary conditions and promote health for people with disabilities. The Department has been awarded a 3-year grant with the possibility of \$1 million in funding to develop an Office of Disability Health. Under this grant, the Department will implement a statewide, collaborative project to prevent secondary conditions and promote health for Vermonters with disabilities, including elders. In implementing this project, we will collaborate with a number of state agencies and community partners including non-profits and disability organizations, and will receive technical assistance from a Massachusetts-based ADA assistance organization.

The goals of the Vermont Disability and Health Promotion Project are to:

- Prevent secondary conditions for people with disabilities through health promotion.
- Decrease the health disparities between people with and without disabilities.
- Ensure that public health disease prevention and health promotion programs are accessible to people across age and disability.

In the first year of the Vermont Disability and Health Promotion Project, we plan to:

- Gather and analyze information on the prevalence of risk factors and secondary conditions for Vermonters with disabilities.
- Identify gaps in information regarding risk factors and secondary conditions for Vermonters with disabilities across age and disability and develop steps to address them.
- Identify gaps in primary care provider knowledge, skills and practice and steps to address them.
- Identify barriers to health promotion programs and steps to address them, including ADA compliance.
- Identify gaps in local health promotion programs and activities and recommend steps to address them.
- Outline the State Plan for Health Promotion for People with Disabilities.

Mental Health in Later Life: Breaking Down the Barriers: Vermont has made significant efforts to ensure that individuals with mental health issues receive the services and treatments they need with the goal of maintaining our citizens in their homes and communities and helping them attain the best quality of life. In spite of these efforts, services for elders have declined precipitously since the 1980's as federal funding changed and the community mental health centers (CHMCs) shifted their priorities to focus on the individuals with severe and persistent mental illness and children with emotional problems. In order to increase awareness and improve mental health services for elders, the Department has been awarded a 17- month \$400,000 grant from the Administration on Aging (AoA). In implementing the project, we will work closely with the Medicaid Division (the Office of Vermont Health Access), the Department of

Developmental and Mental Health Services and many community partners such as the Area Agencies on Aging, Home Health Agencies, Adult Day Centers, the Community of Vermont Elders and the Alzheimer's Association.

The key goals of the project are to:

- Improve the general public's knowledge of mental health issues, services and treatment;
- Improve the knowledge base of elders and their families concerning the area of mental health and aging;
- Improve the knowledge, skills and attitudes of the physicians of the future (University of Vermont medical students) in the field of mental health and aging;
- Improve the knowledge, skills and attitudes of currently practicing physicians and their staff in the field of mental health and aging;
- Improve the knowledge, skills and attitudes of human service agency staff who work with elders and their families; and
- Create an ongoing ability to continue the work started under this grant.

We will meet our goals using the following steps:

- Build the capacity to deliver training to a variety of organizations and professions by researching and testing various training methods.
- Strengthen our relationships with the many agencies/organizations who have been identified as likely partners in providing the training.
- Develop educational and information materials for the general public, physicians and their staff, medical students and elders and their families.
- Provide public education through a variety of public forums focused on topics such as dementia, depression, substance abuse and polypharmacy.
- Contract with a social marketing firm to develop a public education campaign designed to begin erasing the stigma around mental illness.

Dementia Care Grant: Building the Capacity in Vermont: In July 2000, the Department was awarded a three-year \$350,000/year AoA Alzheimer's Disease Demonstration Grant, aimed at improving our ability to meet the needs of persons with Alzheimer's Disease and related dementia and their caregivers. In implementing this grant, the Department is working closely with the Alzheimer's Association, adult day programs, AAAs and professional caregivers.

The grant includes five major objectives:

- Improve the capacity of Vermont's Adult Day Centers to deliver quality care to individuals with Alzheimer's Disease and related dementias .
- Provide direct services such as home health care, personal care, adult day care, companion services and other respite to individuals with Alzheimer's Disease and related dementia and improving the responsiveness of existing home and community-based services.

- Develop support services for individuals with early-stage dementia and their families.
- Improve the early detection of dementia through education of medical professionals and use of a screening tool.
- Increase the public's knowledge about Alzheimer's Disease and related dementia, particularly the benefits of early detection, treatment and services and the value of Adult Day services.

In order to achieve our goal, the following activities are underway:

- Assessment of the capacity of the state's adult day programs to meet the needs of persons with Alzheimer's Disease and related dementia.
- Development and delivery of an education plan for adult day programs, specifically designed for various levels of caregivers and based upon the findings of the assessments.
- Provision of direct financial support to family caregivers and referral to educational programs and further support provided by the Alzheimer's Association.
- Training for professional caregivers on the use of the 7 Minute Screen, which provides screening specifically for Alzheimer's Disease.
- Development of early stage support groups for persons with dementia and their families.
- Public education, using a variety of methods including public service announcements, sponsoring an Alzheimer's Awareness Program and making information materials readily available in public places.

This grant is coordinated with the Dementia Respite Care Program. For more information about the grant activities, please see pages 51 - 53 of the State Plan.

Vermonters Coming Home: a grant to develop rural, affordable assisted living from The Robert Wood Johnson Foundation (RWJF)

In partnership with Vermont Housing Finance Agency and the Department of Prevention, Assistance, Transition and Health Access, the Department was awarded nearly \$300,000 from the Robert Wood Johnson Foundation and technical assistance from the National Cooperative Bank Development Corporation to make assisted living more feasible in Vermont. RWJF established its Coming Home initiative in response to findings that frail rural elders are more likely than their urban counterparts to enter nursing homes. During the three-year initiative ending in 2004, Vermonters Coming Home will:

- Support at least four demonstrations in assisted living;
- Provide technical assistance to as many other projects and community groups as possible;
- Identify and change policies and practices to encourage the development of high quality assisted living and residential care;

- Improve public resources and other supports so that assisted living is more viable for providers and more affordable for consumers;
- Sponsor an annual conference to share expertise and best practices;
- Identify the amount of assisted living that will be needed through the aging of the baby boom generation;
- Make plans with local communities and regions about where, when, and at what scale assisted living will be needed in local and regional areas; and,
- Publish information about assisted living development and best care practices.

The following pages provide an overview of the services funded by Titles III and VII of the Older Americans Act as well as other funds directly administered or linked to the Department of Aging and Disabilities administrative operations.

PROGRAMS FUNDED UNDER THE OLDER AMERICANS ACT

Titles III of the Older Americans Act (OAA) is the primary funding source for a large portion of the state's services to older Vermonters. In addition to the Department, the state's five Area Agencies on Aging, Vermont Legal Aid and the State Long Term Care Ombudsman program all benefit from this funding source and are responsible for meeting the intent and purposes of the Act. The OAA focus is on assisting older individuals to remain independent and providing leadership in the development and support of a comprehensive system of long-term care services. The OAA directs the State and its grantees to ensure services reach those individuals with greatest social and economic need, including low-income minorities. In the AAA Area Plan Instructions for FFY 2003 – 2005 the Department has specified that at a minimum of 65% of the Title III-B funds must be expended on access, 1% on in-home services and 10% for legal assistance. These minimum proportions have been long-standing requirements for which the Department received input from the AAA at the time of implementation and have not changed for several years. The goal of establishing these particular minimum proportions that must be spent on the services is to ensure an adequate level of service, when also considering other resources available to support such services, while at the same time, permitting AAA optimal flexibility to plan services and address the needs identified through their regional needs assessment and planning processes.

TITLE III SERVICES

Information and Assistance

Goals: #1, 3, 4 and 5

For many elders and their caregivers, the Information and Assistance (I&A) Program is the gateway to accessing essential resources to help elders remain as independent as possible and to participate in and contribute to their community. Ready access to information and assistance on a broad array of topics, from senior meal sites to support groups to respite services, is available to elders and their families by calling the 1-800 # of the Senior HelpLine. Since its expansion in 1995 to all five AAA regions of the State,

HelpLine utilization has grown significantly. In FFY 2001, I&A staff fielded 22,027 calls, an increase of 52.3% from FFY1997.

Recently, a number of AAAs have purchased, or are considering purchasing, specially designed I&A software to assist in managing and updating information about services and resources, and providing valuable data about the services provided. AAAs have been actively participating in regional and statewide meetings planning for the implementation of the Statewide 211 Information and Referral System and have taken advantage of national training and conferences on providing high quality I&A services.

With the authorization of the National Family Caregiver Support Program in FFY 2001, significant additional resources have been invested in Information and Assistance in order to expand and enhance services provided to family caregivers. In addition to increasing staff and enhancing the capacity of the Senior HelpLine to respond to callers, AAAs are developing web sites, developing and/or purchasing printed materials and providing I&A outreach at Housing and Supportive Services (HASS) sites and other locations throughout the state.

In an effort to ensure that elders, people with disabilities and their families are able to identify and access the information necessary for them to make informed decisions about long term care and services, the Department contracted for the development of a public communication plan. As part of this plan, the Senior HelpLine will be heavily promoted and, it is expected, demand for I&A services will increase as a comprehensive source for aging- specific information statewide. Other activities planned as part of this effort include the development of a comprehensive brochure, the development of public service announcements (PSAs) for the media, consumer advertising and web site development.

Objectives

1. Develop the capacity for technical assistance and information sharing among I&A staff at the AAA, HHA and other locations.
2. Review policies, procedures and protocols utilized by providers to develop consistency in practice throughout the state.
3. Develop and implement State standards for information and assistance that meet new national standards currently under development.
4. Participate in and support the efforts of the Statewide Coalition established to plan and implement the Statewide 211 Information and Referral Service.
5. Encourage the use of professionally designed I&A software/databases to manage resource and program utilization data.
6. Develop and implement a comprehensive statewide communication plan.
7. Over the course of the State Plan, it is anticipated that the number of calls to the Information and Assistance Program will increase 5% from the FFY 01 level of 22,027 to 23,128.

Case Management Services
Service Coordination and Advocacy
Goals: # 1, 2, 3, 4 and 5

Case managers play a vital role in helping elders and their families to build upon their strengths, garner new resources and develop a solid plan for achieving the goal of maximum independence. The Department has worked closely with the Area Agencies on Aging, as well as the Home Health Agency network, to develop a comprehensive approach to the provision of case management services. It has become apparent that the roles and responsibilities of case managers have changed dramatically to meet the needs of an increasingly frail, older population with complex needs.

In FFY 2002, the Department, working in collaboration with the AAAs and Home Health Agencies, established Standards for Case Management Agencies, Standards for Case Management and Procedures for Case Management Certification. The Standards and Certification Procedures apply not only to case management services provided under the OAA, but also to those provided through other Department administered programs, including the Home and Community Based and Enhanced Residential Care Medicaid Waiver programs. As part of this process, a formal definition was established for Case Management services provided through programs administered by the Department, including those within the Title III activities performed by the AAAs:

"Case management is a professional service to help older adults and younger adults with disabilities access the services they need to remain as independent as possible in accordance with the wishes of the individual, and/or working with a legal representative of that individual, and advocating on behalf of that individual for needed services or resources. Case management targets those individuals with psychosocial or medical needs that extend beyond either advocacy counseling, public benefits or financial issues. Case Management includes:

1. completing a comprehensive assessment to identify the individual's strengths and needs, (including the physical, psychological, financial, and social needs of the individual) and discussing and offering options;
2. arranging for and coordinating an efficient and effective package of services to meet the needs of the individual. This includes the development and implementation of an Action Plan/Care Plan with the individual and/or family to identify and access the formal and informal resources and services which are necessary to meet the identified needs of the individual;
3. monitoring the formal and informal services delivered to ensure that services specified in the plan are being provided and that the individual's identified needs are met; and
4. performing periodic reassessments of the individual with the individual and/or if necessary, with the primary caregiver or family member, and revising the Action Plan as needed."

As the responsibilities and standards for case managers have increased, so has the investment in case management training. In order to enhance the role, professional growth and understanding of case management, the Department, sponsored regular case management training as it developed the Standards and Certification Procedures. In FFY 02, the Department provided financial support to the AAAs to develop and implement a comprehensive case management orientation and training plan which will be available to all case managers providing services under Department administered programs.

In FFY 2001 AAA Case Managers provided 56,396 units of service to 8,160 elders. This represents a 16.6% increase from the 48,370 units of service provided and an 11.7% increase from the 7,307 elders who received case management in FFY 1999.

Objectives

1. Carry out a Case Management Quality Assurance initiative throughout the state, by service region, to provide on-site technical assistance, evaluation and follow-up to providers of case management services.
2. Provide support for on-going training and development of case management staff.
3. Provide technical assistance and encourage AAA to consider developing a fee for service case management program, separate and distinct from those provided under the OAA, to bring additional resources and strengthen the foundation of the case management program overall.
4. In anticipation of level funding and the development of policies and procedures related to the prioritization and caseload management of case management services, the number of elders to receive case management and the volume of services are expected to remain level with the 8,160 elders served and 56,396 units of service provided in FFY 01 over the course of the State Plan.

Nutrition Services

Goals: #1, 2, 4 and 5

Vermont's Nutrition Program provides nourishing meals, nutrition screening and nutrition education to older persons in both community and home based settings. A substantial number of participants, especially those receiving home delivered meals, are at nutritional risk due to limited income, disability or isolation. The Nutrition Program contributes to the overall physical and emotional health and well-being of all participants by: serving meals that contribute to nutritional needs; providing health promotion and disease prevention information and services; providing opportunities for social interaction; and facilitating access to referral information and other services.

Every year, the Nutrition Program has grown, opening new sites, adding days of service and expanding delivery days and routes of home delivered meals. In FFY 2001 more than 967,000 meals were served to more than 12,000 elders in their homes and community meal sites. Since 1997, home delivered meals have increased 26% and in 2001 accounted for 59% of the meals served, reflecting a trend whereby an increasingly frail population is served by the program. The demand for these services outstrips

current funding and many isolated communities continue to have either limited or no access to this essential service.

Since FFY 1998 the Department has collaborated on a number of initiatives with the Area Agency Nutrition Program Directors. These include: revision of the *Vermont Senior Nutrition Program: Program Management Handbook* and in-service trainings on using the handbook; certification of Nutrition Program staff as SERVSAFE Safe Food Handlers; development and implementation of statewide diabetes menu planning standards and in-service training with AAA Nutrition Program staff and local providers; and hosting an annual conference for local nutrition providers. In addition, the Department worked with a national consortium of state unit on aging nutritionists to revise the Nutrition Screening Initiative *DETERMINE Your Nutritional Health* checklist, which is now part of all assessments performed by AAA staff and Home Health Agency Medicaid Waiver case managers.

The following objectives will be developed and implemented in close collaboration with the AAA Nutrition Program staff.

Objectives

1. Provide on-going monthly in-service trainings to AAA Nutrition Program staff and/or local nutrition service providers on issues related to implementation of the Older Americans Act including: nutrition program standards, menu planning, food preparation techniques for modified and special diets, safe food handling, and other relevant nutrition and health promotion topics;
2. Revise the Department Nutrition Program Policies and Procedures;
3. Develop a Department protocol and tool for monitoring the AAA Nutrition Program.
4. Develop a system for prioritizing and targeting services to elders in greatest economic and/or social need, with particular attention to low-income minorities;
5. Ensure the quality and delivery of meals and other nutrition services through the use of performance standards, outcome based measurements and quality assurance protocols;
6. Provide technical assistance to the Registered Dietitians contracting with Area Agencies on Aging;
7. Provide on-going technical assistance in the collection of NAPIS data to support reporting, advocacy and targeting of resources.
8. In anticipation of level funding and the implementation of prioritization and targeting of services, it is expected that the FFY 01 service level providing 967,000 meals to over 12,000 elders will remain constant over the three-year period of the State Plan.

Health Promotion and Disease Prevention

Goals: #1, 2 and 6

Acting on the knowledge that lifestyle choices have a greater impact than heredity on health, functional capacity, quality of life and independence, the Department launched a new initiative on Successful Aging and Independent Living, or SAIL, in January 2000,

with the convening of a statewide task force. In order to accomplish its mission of supporting Department efforts to improve the health and well-being of older persons, four outcomes for successful aging and independent living were adopted, Older Vermonters: (1) have a low risk of disease and disease-related disability; (2) maintain high physical and mental function; (3) are as engaged in life as they prefer; (4) live with dignity and independence in the setting they prefer. The SAIL outcomes serve as a useful framework for guiding many Department activities. In addition, there are quite a few indicators for tracking progress on the SAIL outcomes that were also adopted. Many of the indicators coincide with the goals outlined in *Healthy Vermonters 2010*, the Department of Health blueprint for improving public health over the next decade. A preliminary report on baseline data was released in May 2001. The Department will compile a biennial update on targeted indicators in its *Vermont SAIL Report*. The Task Force meets at least quarterly and has three subcommittees. The conference planning committee is responsible for planning an annual SAIL Summit for the network of service providers for older persons and adults with disabilities. The data committee reviews data sources and determines indicators to be included in the *Vermont SAIL Report*. The inventory committee will identify community-based SAIL activities and develop a system for maintaining an updated directory of these resources.

The Department collaborates with the Vermont Department of Health on a number of health promotion and disease prevention initiatives, including the Diabetes Coordinating Council, the Injury Prevention Task Force and the Cardiovascular Health Coalition. The Department is also an active participant on the Vermont Osteoporosis Task Force. Collaboration with the University of Vermont (UVM) is growing. We continue to serve as mentors/supervisors for Human Nutrition students enrolled in the Community Services Practicum at the UVM Department of Nutritional Sciences. Further, the Department is a consultant on a UVM research project evaluating the effectiveness of using computer technology to deliver nutrition, health promotion and food safety information to elders. The Department also participates in the National Association of State Units on Aging (NASUA) Health Promotion and Disease Prevention initiative.

Objectives

1. Expand participation in the SAIL initiative by recruiting new members and retaining existing members.
2. Continue hosting a high quality annual SAIL Summit;
3. Develop an inventory of statewide community-based SAIL activities and build capacity for maintaining an updated directory;
4. Update the *Vermont SAIL Report*;
5. Continue collaboration with the NASUA, Vermont Department of Health, Vermont Osteoporosis Task Force, UVM, AAAs, long-term care coalitions and other health promotion groups on initiatives that provide information and services that promote successful aging and independent living.
6. In anticipation of level federal funding and Vermont's unstable economy, it is expected that the four broad outcomes for Successful Aging and Independent Living will remain stable over the course of the State Plan. Again, the four broad outcomes

include: 1) low risk of disease and disease-related disability, 2) maintenance of high physical and mental function, 3) engagement with life; and 4) living with dignity and independence. Please refer to pages 10 – 12 for the specific data related to these measures.

National Family Caregiver Support Program

Goals: #1, 2, 3, 4 and 5

Family caregivers provide the bulk of care to elders, contribute their own funds to the care of their family member, often giving up or limiting other personal goals or interests. Now, with the OAA's newest program, the National Family Caregiver Support Program (NFCSP), new resources are available to provide services and support specifically designed for caregivers. The five categories of activities allowed in this program include: 1) information to caregivers about services, 2) assistance to caregivers in accessing services, 3) individual caregiver counseling, caregiver support groups and training, 4) respite; and 5) supplemental services. Vermont provides all of these types of services, either with NFCSP funding, or with other resources. It should also be noted that in addition to providing services to caregivers of elders, the program also includes services for grandparents and other older relatives who are caregivers of children, referred to by some as Kinship services.

Because Vermont already has in place a strong network of services and systems that provide assistance to elders and their caregivers, the general approach in implementing this program has been to expand and enhance the existing systems, with a specific emphasis on caregivers. In its first year of implementation, FFY 2001, AAAs held focus groups to gain insight into the issues and needs of caregivers, provided information about available services, expanded the types and amount of information available to caregivers, provided assistance in accessing services and case management to caregivers. In addition, work is underway to establish new caregiver support groups and a “first in Vermont” elder caregiver resource center. Respite programs have been expanded and services extended to caregivers that previously had no such resource. Special community grants were funded in one region of the state for local organizations to design and provide innovative services.

There has been tremendous interest in the NFCSP in Vermont; and the program has served as a vehicle to establish relationships with new groups of community partners. Interest is high from those working with families to explore new ways to support grandparents and other older relatives who are caregivers of children. A presentation and information was provided to the Statewide Family Consortium, comprised of numerous groups working with families and disability issues, and the State and AAA NFCSP Coordinators presented a workshop at the 2002 Governor's Conference on Prevention as the theme this year was *Caregiving Through the Life Span*.

In FFY 2003, the State intends to use NFCSP funds to provide all five categories of services using NFCSP funds. Although the Department and AAAs are still in the AAA Area Plan Approval process, the very initial projections for the amount of funding that

will be spent in each category of service and the projected number of caregivers who will benefit from the services is outlined below. ***It is important to remember that these projections are only that: projections, and that changes may occur throughout the AAA Area Planning process.***

<u>Category of Service</u>	<u>Projected Funding</u>	<u>Projected # of Caregivers</u>
1. Information	\$112,395	6,401
2. Assistance	\$366,057	4,804
3. Training/ Support	\$79,250	760
4. Respite	\$85,000	157
5. Supplemental Services	\$5,000	12
Total*	\$647,702	12,134

**The projections above include a projected \$24,275 to be spent providing services to a projected 138 grandparents or other older relatives who are caregivers of children.*

Objectives

Since this program is still very much in the development phase, future objectives for this program include:

1. Participate in and collaborate with AAAs and other community partners working to support family caregivers.
2. Use the SAMS database, or other appropriate database, to consistently capture data about the caregivers receiving services and program utilization.
3. In consultation with the AAAs, develop and implement Vermont NFCSP standards, upon issuance of the revised federal OAA regulations.
4. Provide technical assistance to AAA NFCSP Coordinators and other staff related to implementation of the NFCSP, federal NFCSP regulations and program development.
5. Please refer to projected number of caregivers to be served in each category of service above.

TITLE VII SERVICES- ELDER RIGHTS SERVICES

Adult Protective Services

Goals: #1, 2 and 6

Vermont’s Adult Protective Services (APS) program operates within the Division of Licensing and Protection. APS receives reports and investigates allegations of abuse, neglect and exploitation of elders and adults with disabilities residing in a variety of settings. Five full time field investigators and two registered nurse surveyors trained in APS investigative procedures conduct these investigations.

The program's operating philosophy supports client directed services. There is a strong belief that clients of Adult Protective Services can and should make their own decisions and choices, so long as they have the capacity to do so.

In SFY 2001 APS received 1,528 reports of alleged abuse, neglect and/or exploitation. Services include intake, screening, case consultation, investigation and protective services. Protective services may include unlawful trespass and/or restraining orders, guardianships, assistance in securing emergency services such as housing and emergency food assistance, and collaboration with law enforcement personnel on joint civil/criminal investigations on behalf of clients. Each year APS provides hundreds of case consultations and referrals, to ensure that clients are linked to community service providers who can help them remain safe and secure. APS accepts reports of self-neglecting adults who are under 60 years of age, with a diagnosed disability. Reports of elder self-neglect are referred to one of the state's five AAAs.

The APS Program maintains Vermont's Adult Abuse Registry. When an individual is found to have abused, neglected or exploited a vulnerable adult, that person's name is added to the Abuse Registry. Hundreds of Vermont employers check the Registry each year prior to offering an applicant employment, thus screening out people who have a history of abusing vulnerable adults. Last year APS ran almost 14,000 Abuse Registry checks for Vermont employers.

Prevention of adult abuse is important to the APS mission and one of the best prevention tools is education. In FY 2001 APS provided in-service education to 766 people through 26 on-site education programs. These efforts will expand these efforts in the next three years.

APS achieves many successful outcomes for adult victims of abuse. Frequently these successes are the result of close collaboration with community service providers, especially Area Agencies on Aging, home health agencies, licensed facilities and community mental health providers. The APS Program could not do its job without these cooperative and collaborative partnerships.

Objectives

1. Expand access to training for service providers, including new mandated reporters in senior centers and nutrition programs, on abuse prevention and intervention, to strengthen community capacity to prevent and detect abuse, and ensure intervention and supportive services for victims.
2. Explore development of an APS video-training program, with a companion train the trainer program, targeted to nursing home, residential care and assisted living providers.
3. Expand the Division of Licensing and Protection's Web page to include a section on Abuse Prevention Q&A to expand public access to information, referral and services.
4. Develop an education program in collaboration with other organizations committed to abuse prevention, which targets law enforcement personnel, especially local police and sheriffs' departments.
5. Because of significant changes to the Adult Abuse Statute, including a significant change in the definition of who the statute applies to from "elderly and disabled

adults” to “vulnerable adults” and changes in mandatory reporters, it is difficult to predict how this will change the number of reports that are made and how many investigations are conducted. These changes did not go into effect until July 1, 2002. Therefore, it is anticipated at this time that the number of reports will remain constant at the 1,528 reports filed in SFY 01.

Legal Assistance

Goals: #1, 2 and 4

The Department of Aging and Disabilities provides Title III-B funding to the five Area Agencies on Aging, who in turn purchase legal services from three providers on behalf of elderly Vermonters within their service regions. Four AAAs contract with Vermont Legal Aid, Inc. to provide advice, advocacy, and legal representation through the Senior Citizens Law Project (SCLP). The SCLP employs approximately 3.5 full time employees, with a full or part-time staff attorney dedicated to each AAA service region. The fifth AAA (Northeastern Vermont Area Agency on Aging) has elected to use its Title III-B allocation to contract with private attorneys for advice and legal representation for individual clients. Four AAA contract with Vermont Legal Aid, Inc. to provide advice and legal representation to individual clients and advocacy on systemic issues, as well as training and technical support to AAA staff and advice on matters within its expertise to private attorneys, through the Senior Citizens Law Project (SCLP). The fifth AAA contracts with the SCLP for advocacy on systemic issues and to provide technical assistance to the contract attorneys and advice to private attorneys within their service area. Legal service providers collectively deliver free legal representation in approximately 700 cases each year. The providers prioritize their intake and caseload to assure that services are targeted to clients in greatest social and economic need. In the past year, there has been increased emphasis on ensuring that the very frail and/or most vulnerable clients receive case management services from the Area Agencies on Aging. However, the AAA continue to provide thousands of Vermont elders with assistance, and hundreds are referred to, or directly contact Legal Aid for legal assistance.

High priority cases generally addressed by the legal services providers include eligibility and coverage issues involving public benefits, access to health care, planning for long-term care and for incapacity, financial exploitation, landlord/tenant and other housing issues, guardianship and protecting the civil rights of elders living in institutions, such as nursing homes. Other lower priority cases are typically referred to the Legal Service Law Line of Vermont, an LSC-funded provider of telephone legal advice, or to private attorneys who have agreed to provide representation for free or at a reduced rate through a referral program maintained by the SCLP.

Legal service providers provide ongoing technical assistance and backup to the network of 75 case managers/advocates employed by the five AAA. These case managers provide many of the referrals to the providers and often work closely with attorneys on cases involving guardianship, consumer protection and public benefit entitlement cases.

The Little Legal Handbook for Older Vermonters, published by the Champlain Valley Agency on Aging on behalf of the five AAAs with the assistance of Vermont Legal Aid and the Elder Law Committee of the Vermont Bar Association is a valuable and popular resource for older Vermonters and their families. It was updated and reprinted in 2002.

Objectives

1. Provide high quality advice and legal representation to Vermonters age 60 and older who are in the greatest social and economic need.
2. Identify and provide advocacy on systemic issues such as access to health care, financial exploitation, guardianship and the civil rights of institutionalized elders.
3. Assure the coordination of services with other legal services providers, including Legal Services Law Line, the Office of Health Care Ombudsman, the Vermont Ombudsman Project (VOP) and other projects of Vermont Legal Aid, Inc., and private attorneys.
4. Provide leadership in the practice of elder law through active participation in the Elder Law Committee of the Vermont Bar Association and other local and statewide groups.
5. Provide training and technical assistance to AAA staff, private attorneys, and consumers.
6. Conduct outreach to increase awareness among Vermont elders and the public generally of the availability of legal services.
7. Increase the number of private attorneys available to represent senior citizens in areas such as long-term care planning and public benefit programs and improve their knowledge about elder legal issues through seminars and other continuing education opportunities.
8. In 2001, the Abuse Prevention Statute was comprehensively revised for the first time in 10 years to enhance protections against abuse, neglect and exploitation. The Department, in cooperation with Vermont Legal Aid, intends to improve training programs to inform providers and consumers about the new law.
9. Establish an ad hoc committee to review suspicious, unexplained and/or untimely deaths of elders in home, community and facility-based settings.
10. Establish a statewide team to enhance information sharing and prosecutorial efforts in elder abuse and financial exploitation cases.
11. Create a consumer information pamphlet on powers of attorney.
12. Create a practice manual for attorneys, particularly regarding best practices for powers of attorney.
13. In anticipation of level funding, maintain annual service level at 700 cases per year.

Office of Long Term Care Ombudsman

Goals: #1 and 2

The Department of Aging and Disabilities contracts with Vermont Legal Aid, Inc. to operate the Vermont Ombudsman Project (VOP) - 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 Ombudsman who supervises four full-time, regionally based ombudsmen plus a fifth ombudsman who divides her

time between ombudsman duties and coordinating the project's volunteer program. In addition to paid staff, the project utilizes 14 certified volunteers and an additional 12 volunteers in training. Ombudsmen are available to residents in all Vermont nursing homes and residential care homes.

In 2001, all ombudsmen began using a statistical reporting system that enhances their ability to analyze and review data. The new system fully crosswalks with the National Ombudsman Reporting System (NORS) database and allows the project to generate timely and accurate reports about ombudsman activities and services provided.

In FY 2000, the state legislature allocated an additional \$100,000 to the project. Ombudsman services in Vermont had been level funded for over 10 years. The new funds allowed the project to hire additional staff so that currently there is a regional ombudsman in each of the five AAA service areas. With additional staff, the project now has the resources to recruit and train new volunteers. These volunteers ensure that long term care facility residents throughout the state will have timely access to quality ombudsman services. The paid staff directly handle the more difficult cases/complaints which require a higher level of training or expertise, with many of the simpler problems experienced by residents, (most of which are susceptible to quick resolution) handled by volunteers in consultation with paid Ombudsman staff.

The number of nursing home beds in Vermont is declining. Many people now have the opportunity to receive nursing home level of services in a community-based setting. Although this is a positive change in the way long-term services are provided, it creates new challenges for the state and the ombudsman program. Two Vermont nursing homes closed their doors in 2001 and, as the shift to community-based care increases, it is likely that more facilities will close. It is critical that there be safeguards in place to protect the health, safety and welfare of the residents during the closure and that there be a well designed relocation plan in place that informs residents and their families of their options early on in the process and helps them find appropriate alternative placements. In addition, as more and more vulnerable individuals receive nursing home care in community settings, it is important to make sure that the health, safety and welfare of these individuals are also protected.

Objectives

1. Continue to recruit and train volunteers to maximize ombudsman services to residents in facilities throughout the state.
2. Explore ways to extend ombudsman services to elders receiving nursing home level of services in the community.
3. Implement safeguards through legislation, regulation or written protocols that will protect residents when facilities close.
4. In anticipation of level funding, the following annual service levels are expected throughout the State Plan period: respond to 550 complaints, provide 250 consultations to facilities or individuals; and conduct 100 non-compliant resident visits.

Office of Public Guardian

Goals: #1, 2

Vermont has a small (5.0 FTEs) Office of Public Guardian (OPG) which provides guardianship services to persons over age 60 for whom there is no one else willing or suitable to serve as guardian. The Office is permitted by statute to limit the caseload in order to ensure quality services, and it is currently limited to 80 individuals. The recent addition of another FTE will allow the director of the program to concentrate on educating Vermonters about alternatives to guardianship and to recruit volunteer guardians.

A legislatively mandated study of the OPG has recently been completed and contains several recommendations for addressing the continued unmet need for guardianship services. The Department may choose to implement some or all of the recommendations.

Outreach, Counseling and Assistance

Goals: #1, 2

The five Area Agencies on Aging provide counseling, advocacy and assistance to thousands of older Vermonters each year. In doing so, they identify those individuals in greatest need and ensure that this community based service allows them to access benefits and services to support independent living to the greatest extent possible.

There are approximately 75 Case Managers who perform outreach, counseling and assistance services participate in a variety of training programs to support and expand their knowledge about case management, which includes outreach, counseling and assistance. In addition, some AAA I&A Programs now employ Outreach Specialists who provide outreach to individuals and groups, Food Stamps Outreach Specialists who work to increase elder participation in Food Stamps and case management and other staff who provide direct assistance with accessing and maintaining Medicaid eligibility. In FFY 2002, the Department, with support from the five AAAs, entered into a grant agreement with the Central Vermont Council on Aging to develop and implement a long range, comprehensive plan for on-going training in the areas of community and Long-Term Care Medicaid and other public benefits; providing services to clients at risk for self-neglect and/or abuse; and other issues related to elder rights. The AAAs work closely with providers of elder law services and those departments which administer public benefits such as food stamps, fuel assistance and related resources.

These services are provided under the Case Management and Information and Assistance systems of services and through the Food Stamp Outreach and Medicaid Administration Programs and are designed to ensure individual choice, confidentiality and the individual's right to be an active participant in planning for and accessing the services s/he most prefers. Further detail and objectives related to these activities are described on pp. 37 - 38 Case Management Services.

Objectives

1. Please refer to the objectives outlined for Information and Assistance on pp. 35 – 36 and Case Management Services on pp. 37 – 38 of the State Plan.

PROGRAMS FUNDED with OTHER RESOURCES (and/or in conjunction with OAA funding)

Transportation

Goals: #1, 2 and 4

The issue and need for transportation permeates almost every activity or initiative in which the Department is involved. Access to transportation services, which are flexible and responsive to the varied needs of elders is critical to the success of all long-term care services outlined in this plan; and there continues to be a looming gap in our ability to meet this constant and expanding need. The Department works closely with numerous state and local agencies to ensure that consumers have access to transportation services designed to maintain independence and promote access to needed community services and resources.

Area Agencies on Aging and adult day centers receive \$500,000 from the Department to purchase, provide and help coordinate accessible transportation services on the local level. Overall, in FFY 2001 AAA supported the delivery of 73,620 one-way trips to Vermont elders and spent \$30,464 in OAA funds on transportation. This funding is important to ensuring that these key community services have the capacity to meet consumer needs. Beyond providing funding, these agencies invest a significant effort into working, negotiating and communicating with transportation providers to ensure that elders receive high quality, accessible services that will allow them to access needed services and important community events.

On the state level, the Department is very involved with regional planning commissions, the Agency of Transportation, human service and public transit providers, and consumer and advocacy organizations in carrying out the Section 5310 Transportation Program. This program is specifically established to meet the special transportation needs of older persons and persons with disabilities. Vermont is one of a handful of states which has worked to promote coordination of human services and public transportation by using funds from this program to not only purchase vehicles, but to purchase or provide special transportation services.

The Department co-chairs the Statewide Advisory Committee with the Agency of Transportation and is responsible for reviewing applications and making recommendations on funding. Since FY 99, a great deal of progress has been made to increase the regional coordination and planning for these services. We anticipate that demand for this type of special transportation funding will continue to grow with the

increasing population and with the development of new and innovative approaches to providing long-term care services in the community.

Another important state transportation initiative involves the Public Transit Advisory Council (PTAC). Established by the 2000 State Legislature, this council is charged with evaluating and making recommendations regarding a broad range of issues in public transportation including funding and allocation, planning and establishing performance standards. The Department represents the Agency of Human Services on this Council. Over the past year, the PTAC has provided input on a number of issues including: the Job Access Reverse Commute (JARC) programs, the development of a funding allocation formula for public transportation, criteria for new service and continued funding of existing routes and the development of coordinated regional short range transit plans.

The Department has also been active in examining the issue of public safety and older drivers, participating in a state-level task force convened by the Department of Motor Vehicles and including AARP and the Department of Public Safety. The task force is charged with making recommendations to inform the Department and the state legislature. This group began meeting in 2002 and has begun collecting information and data, identifying gaps in information and surveying drivers about their driving habits, opinions and access to public transportation.

Objectives

1. Conduct a public survey of issues related to special needs transportation such as consumer satisfaction, current utilization, unmet needs and ideas to improve access and accessibility.
2. Encourage and collaborate with state agencies directly administering transportation programs to develop and implement quality assurance methods and clear, consistent consumer grievance procedures.
3. Work collaboratively with the Vermont Agency of Transportation (VTrans), the Vermont Public Transit Association (VPTA), AAA, consumer organizations and our other community partners to support the expansion of an efficient and coordinated public transit program that expands access for elders, maximizes available resources and ensures quality of service, as well as adequate resources to support such service.
4. Identify new, flexible approaches to transportation, as part of the existing services or as a complement to them, that can accommodate the special needs of elders and persons with disabilities.
5. Advocate for consistency within the public transit system in the areas of fees, rules and procedures for service.
6. Promote increased education and training of both paid and volunteer drivers, which supports a consumer responsive system of public transit service.
7. Promote the implementation of least restrictive methods of ensuring public safety with older drivers, including safe driving training, screening and correction of health issues affecting safe driving and environmental and design changes to promote safe driving by Vermont's elders.

8. AAA will maintain the FFY 2001 service level of 73,620 one-way trips provided to Vermont elders.

Adult Day Programs

Goals: #1, 2, 3 and 4

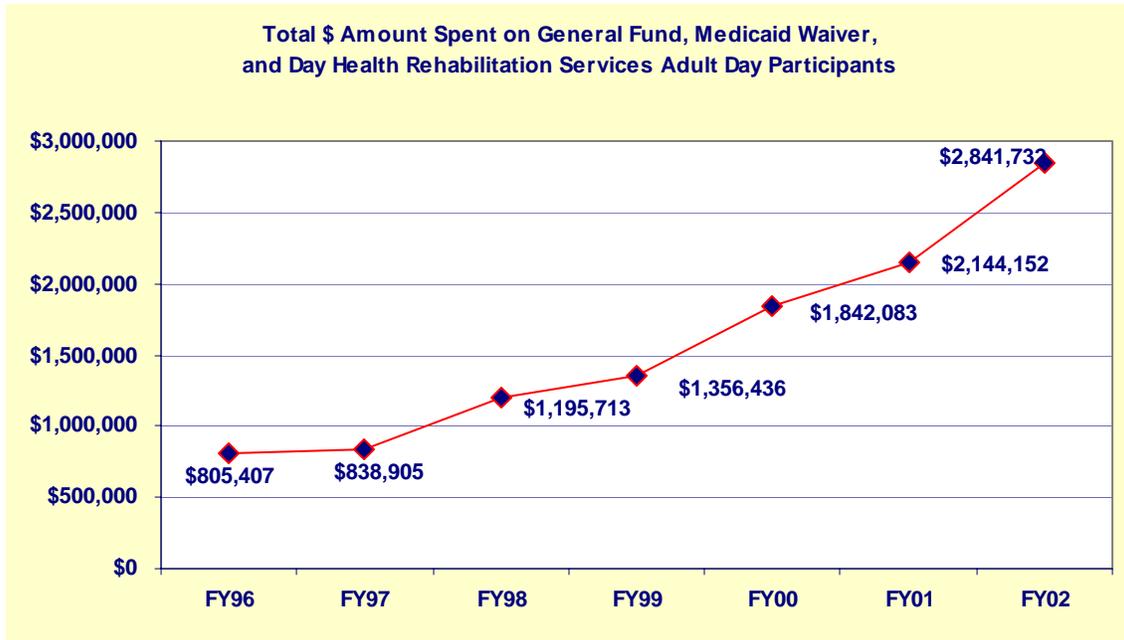
Adult Day Programs represent one of the Department's most important initiatives in the expansion of our capacity to serve older people who need an array of services to support their ability to remain at home. For this population, access to both medical and social support systems is essential.

An exciting development in Medicaid funding for Adult Day Programs came in July 2000 with the introduction of the Day Health Rehabilitation Services (DHRS) Program. Day Health Rehabilitation Services are provided to individuals with physical or cognitive impairments who are not residing in a nursing home, nor receiving enhanced residential care services or other similar services. Day Health Rehabilitation Services are intended to maintain optimal functioning and prevent or delay the need for the level of services provided in a nursing facility.

Also in 2000, the Vermont State Legislature appropriated one-time funding in the amount of \$500,000 to support the infrastructure enhancement needs of Vermont's Adult Day Programs. Infrastructure enhancement grants assisted Adult Day Programs in building their capacity in a variety of ways; including moving to new, larger facilities, renovating and expanding existing facilities, and purchasing necessary furniture and equipment.

Adult Day Programs have continued to experience steady growth in both the number of persons served and in the quality and amount of services provided. Vermont has 12 state funded Adult Day Programs, with 15 sites around the state. From SFY98 to SFY01, the number of persons served in the twelve state-funded Adult Day Programs increased from 718 to 877, an increase of 18%. In addition, there are two non-state funded programs that receive Medicaid reimbursement through the Home and Community Based Medicaid Waiver and/or Day Health Rehabilitation Services. All sites offer supervision of activities of daily living, therapeutic activities, personal care and professional nursing services. Many sites also have the capacity to provide professional social work, nutritional services, and physical, occupational and speech therapy.

Act 160 funds made a rate increase possible for both Medicaid and State Funded programs for Adult Day services. The Medicaid Waiver rate increased from \$8.20/hr in SFY 2001 to \$10.20/hr in SFY 2002, the Day Health Rehabilitation Services rate increased from \$8.80/hr in SFY 2001 to \$10.80/hr in SFY 2002, and an additional \$200,000 was added to the State General Fund in SFY 2002. The total amount spent on adult day participants through these three programs is expected to total \$2,841,732 in S SFY 2002.



Adult day programs are benefiting greatly from the capacity building activities provided through the AoA Alzheimer's Disease Demonstration Grant. For more information, see pages 33 - 34 of this plan.

Objectives

1. Continue to assist Adult Day Programs in building capacity to meet the increasing demand for Adult Day services.
2. Support the Adult Day Programs' ability to care for an increasingly frail and disabled population.
3. Complete the revision of and implement the Standards for Adult Day Services in Vermont in SFY 2003.
4. Provide training and technical assistance to the Adult Day Programs individually, at the Vermont Association of Adult Day Services bi-monthly meetings, and at the bi-annual statewide Adult Day conference.

Dementia Respite Care Program

Goals: #1, 2, 3 and 5

The Dementia Respite Care Grant Program, a pilot project initiated in 1998 was incorporated into a larger application for the Alzheimer's Disease Demonstration Grants to States (ADDGS). The ADDGS grant awarded in July 2000 is entitled Dementia Care: Building the Capacity in Vermont. This three-year grant has five major goals which include: 1) assessing the capacity of adult day services to provide care to persons with dementia and educating and training adult day providers; 2) providing direct financial support to family caregivers of person with dementia; 3) educating primary care providers in the use of the 7 Minute Screen to screen for early detection of Alzheimer's

Disease; 4) developing supports groups for persons and their families with early stage dementia; and 5) educating the public about Alzheimer's Disease and related dementias.

Goal 1: Assessments of the 16 adult day programs were completed through the use of an evaluation tool designed from the Alzheimer's Association publication Key Elements. A three-pronged educational program was developed from the assessments. The program includes six sessions for adult day direct care providers, one session for executive directors and board members and one session for nurses in adult day services. The Alzheimer's Association (Vermont/New Hampshire Chapter) is responsible for this component of the grant and this work has been carried out with efforts from the project director of the grant.

In addition, two scholarships were made available for adult day nurses to attend the International Human Caring Conference (Creating Caring Environments) held in Boston, MA. May 2002.

Goal 2: Providing direct financial support to family caregivers to meet their needs for respite developed into a statewide program in SFY 2000. The dementia respite grant program is managed through five Vermont agencies (four AAAs and Rutland Community Programs, Inc.). In addition to providing direct financial assistance, the agencies refer grant recipients to the Alzheimer's Association as well as provide outreach to the community.

Since SFY 1999 the dementia respite grant program has grown from serving the initial 40 households to 274 families, a 585% increase. To be eligible for respite grants caregivers must be caring for individuals over the age of 60 with a diagnosis of Alzheimer's Disease or a related dementia and have an income below 300% of the poverty level. Grants ranging from \$1500 - \$3000 are made to families for respite. Families may apply for grants each year. Grant recipients generally use the funds for paid in-home respite provider or for adult day services. Recipients of grants however do have the flexibility to use the funding for respite as they define it to be helpful to their personal welfare. Consequently, caregivers have reported using funds to attend a family function out of state, have time for themselves or to attend doctor's appointments. Caregivers often report that the grants are very important to sustaining their ability to continue in the caregiver role.

All grant recipients are referred to the Alzheimer's Association for additional support. They are provided with education about caring for a person with Alzheimer's Disease or a related dementia. They are also given a directory of respite care providers who have been trained by the Alzheimer's Association. The directory provides names of trained individuals in each area of the State.

Goal 3: Several groups have been trained in the use of the 7 Minute Screen. These groups include medical students, nurse practitioner students and the Eldercare Clinicians employed by the 10 Community Mental Health Centers. The 7 Minute Screen is a reliable and valid tool, which provides screening specifically for Alzheimer's Disease.

Individuals whose scores indicate the probability of dementia can receive further diagnostic evaluation by their primary care provider or be referred to the State's two memory disorder clinics for further assessment.

Goal 4: Development of support groups using the Robin Yale model is being planned for the third year of the grant. The model provides for small group support of the person and the caregiver with a memory disorder. The two groups initially meet together and then divide for the remainder of the meeting so that issues specific for persons with dementia and those of the caregivers can be discussed separately.

Goal 5: The Alzheimer's Association has the responsibility for the public education portion of the program. Several methods including public service announcements, a month long Alzheimer's Awareness Program held in November, and placing material in public libraries and other easily accessible location have been very successful.

Objectives

1. Continue to provide direct financial assistance to family caregivers of persons with Alzheimer's Disease and related dementia.
2. Complete the activities included in the *Dementia Care: Building the Capacity in Vermont Project*, including training, development of support groups, public education and promoting screening and early detection of Alzheimer's Disease.
3. Develop and implement a plan for continuation of direct assistance to caregivers and for an expanded array of activities to build the capacity to meet the needs of Vermonters with Alzheimer's Disease and related dementia.

Mental Health Related Services

Goals: #1, 2 and 6

The Department is aware that services for the aging population with chronic, acute or intermittent conditions, including cognitive, developmental, mental health or substance abuse issues are still inadequate. Current providers often lack the skills and knowledge necessary to work effectively with an older population. Not too long ago, persons with developmental disabilities were not expected to live into old age and cognitive decline and depression were considered a normal result of the aging process. As people with various types of disabilities age, we will face new challenges as we try to find ways to give providers the skills and knowledge necessary to provide quality services. Much of this work will involve building on our working relationships with the Department of Developmental and Mental Health Services (DDMHS) and the Department of Health as well as with our community partners. We will find ways to ensure that all programs and services are tailored to meet the specific needs of elders and that staff receives the necessary training and support to provide quality services. As part of these efforts, there is joint funding from the Department and the DDMHS for a geriatric psychiatrist.

Through an annual General Fund appropriation of \$250,000, the AAAs have been able to contract with their local community mental health centers for the services of Eldercare

Clinicians. These Clinicians provide mental health services to elders, many of whom would otherwise go without services because they are either unable to leave their homes or they are reluctant to visit a mental health center.

To help coordinate the various mental health initiatives in the state, the Department convened an advisory council to address the issues of mental health, substance abuse and dementia. The council has broad representation from both the aging and mental health network.

Objectives

The Department intends to build on the initiatives already underway:

1. Continue to develop and improve the Mental Health and Aging Initiative, which also involves the Department of Developmental and Mental Health Services, the Area Agencies on Aging and the Community Mental Health Centers.
2. Support the work of the Vermont Advisory Council on Elder Mental Health, Dementia and Substance Abuse.
3. Continue training programs presented by a geriatric psychiatrist and other training programs developed by the Office of Alcohol and Drug Abuse Programs (ADAP), the Coalition on Substance Abuse and Older Vermonters, the Alzheimer's Association and other organizations to a variety of professionals and caregivers who work with elders. Training will include topics on dementia, substance abuse, depression and other mental health issues.
4. Continue to support the Governor's Commission on Alzheimer's Disease and Related Disorders.
5. Develop and implement a pilot project aimed at improving substance abuse detection and treatment for elders.
6. Provide public information about mental health, dementia and substance abuse to increase awareness about the issues and available resources.

The Department will also seek funding that will allow us to disseminate and continue the use of the training programs developed under the AoA Mental Health and Aging research and demonstration grant.

Medicaid Home and Community Based Waiver

Goals: #1, 2, 3, 5 and 6

The goal of this program is to support independent living for individuals who would otherwise require nursing home care. By the end of SFY 2003, the Department's Home-Based Medicaid Waiver will operate with a total of 990 slots, an increase of 10.12% over the previous year's 899 slots.

Services provided under this waiver include case management, personal care, adult day services, respite care, companion care, personal emergency response systems, and assistive devices/home modifications. This waiver has been modified to include

consumer-directed and surrogate-directed service options over the last six years. These options now represent more than half of all personal care, respite care, and companion services.

During SFY 2001, 113 people were able to leave a nursing home setting to receive services at home under this waiver. The Area Agencies on Aging have played a significant role in helping the Department expand this service and provide case management services to more than fifty percent of participating individuals. Home Health Agencies have also played a significant role in the expansion of the program, providing case management, personal care attendant services, and other related services.

Objectives

1. Expand the capacity of the Home-Based Waiver by increasing the number of Medicaid Waiver slots available.
2. Increase the availability of paid caregivers by improving wages, benefits, and working conditions.
3. Improve quality assurance and quality improvement procedures for this waiver.

Enhanced Residential Care Medicaid Waiver

Goals: #1, 5 and 6

The Department's newest waiver, the Enhanced Residential Care Medicaid Waiver, provides services in selected licensed residential care homes to people who would otherwise require nursing home care. This waiver offers personal care, activities, case management and the availability of 24-hour staff in home-like settings. As with the Home-Based Medicaid Waiver, AAA case management staff provide a high level of support to this program, through referrals, assessment, work with providers and ongoing follow-up and support to residents.

Objectives

1. Expand the capacity of the Enhanced Residential Care Medicaid Waiver by increasing the number of Medicaid Waiver slots available.
2. Expand the capacity of the Enhanced Residential Care Medicaid Waiver by increasing the number of participating providers.
3. Review reimbursement procedures to assure fair and equitable reimbursement to residential care homes.
4. Increase the availability of paid caregivers by improving wages, benefits, and working conditions.
5. Improve quality assurance and quality improvement procedures for this waiver.

Community Based Coalitions

Goals: #1, 2, 3, 4, 5 and 6

Ten community long-term care coalitions, covering the entire state, now plan for and implement long-term care services in their communities. These Coalitions, which include AAAs, service providers, advocates and consumers, are working to build local capacity to meet long-term care service needs. Their efforts are currently focused on developing a stronger home and community-based system of care that offers elders and persons with disabilities clear choices to meet their needs. To date, ten of these Coalitions have been appropriated in excess of \$1,000,000 in Act 160 funding to implement innovative strategies, as well as tried and true approaches, and increase community collaboration and cooperation.

Objectives

1. Identify ways to ensure effective collaboration and coordination between OAA funded services and programs and those funded through the Community Coalitions.
2. Work with the Coalitions to collaboratively manage those resources (e.g. flex funds, homemaker services, dementia respite care) which offer maximum flexibility to consumers who need a broad range of supports to remain in the community based setting of their choice.
3. Support the expansion of the AAAs role in the development and coordination of the long-term care services delivery system.

Residential Alternatives

Goals: #1, 2 and 6

The Department remains committed to developing a menu of options that combines housing with services to promote aging in place. To accomplish this objective, several significant system changes have been accomplished since the last State Plan:

- The Department established a Residential Alternatives Unit within the Division of Advocacy & Independent Living to serve as a focal point for this work;
- The Department and the Agency of Human Services has developed coordinated reviews with housing funders so that high priority special needs housing projects receive coordinated technical assistance and are more competitive;
- Assisted living and special needs housing have been included as priority needs in the Vermont Consolidated Plan for housing to the U.S. Department of Housing & Urban Development and Vermont's Qualified Allocation Plan for Low Income Housing Tax Credits;
- The Department and the Agency of Human Services worked to establish a Medicaid State Plan personal care program called Assistive Community Care Services for residential care home and assisted living residents, and a Medicaid Personal Directed Attendant Care program. With these programs, the Department builds a continuum of funding that parallels the continuum of care needs across the nursing home level of care guideline; and,

- The Department, together with the Vermont Housing Finance Agency and the Department of Prevention, Assistance, Transition & Health Access, obtained a Robert Wood Johnson Foundation Coming Home grant to make system changes so that developing rural assisted living becomes feasible.

Objectives

1. Planning:

- Develop a state plan for residential alternatives as part of the system-wide capacity study and identify highest need localities and regions.
- Assure that the priority housing needs of Vermont elders are appropriately represented in Vermont's Consolidated Plan to the U.S. Department of Housing and Urban Development (HUD) and the Qualified Plan for Low Income Housing Tax Credits.

2. Access:

- Improve access to residential alternatives by couples who are disadvantaged under Vermont Medicaid rules, Protected Income Limits and Vermont Supplemental Security Income (SSI) living arrangements.
- Prepare younger adults with physical disabilities for community based living in later life by promoting and refining Medicaid working disabled rules and by educating consumers about opportunities to set aside resources and use Section 8 vouchers for home ownership.
- Find funding solutions to the "gaps" between traditional room and board payments and services payments in housing plus services models.
- Build awareness of reverse mortgages.
- Maintain, increase and coordinate Vermont's total home modification resources. Target some resources to persons who, but for a home modification, would be at immediate risk of institutionalization.

3. Choice:

- Consumer Education and Protection: Promote uniform Consumer Disclosure in senior and disabled housing/residential alternatives so that elders are better able to choose the housing or residential alternatives that they prefer.
- Build the capacity of home health agencies to organize staffing in congregate housing to "assisted living-like" levels.
- Study the potential replication of the Group Directed services model, currently in demonstration at Anderson Parkway, South Burlington.
- Continue to promote participation in the Housing and Supportive Services (HASS) program, currently operating at 29 congregate housing sites. Study the application of PACE and the coordination of home health agency services as two strategies to increase service availability to 24 hours per day.

- Work with the private sector to re-establish and promote Elder Cottage Housing Opportunity (ECHO - accessory unit, mother-in-law apartment) housing in Vermont.
- Replicate match-up shared housing programs where possible and partner with SHARE to promote these programs.
- Assist congregate shared housing projects in clarifying and reaching their market niche and making partnerships that promote aging in place for residents; partner with SHARE to promote these programs.
- Establish an adult family care program.
- Promote a universal design knowledge base in Vermont. Work with the housing and assistive technology communities to co-promote Vermont's standards for adaptable and visitable housing units.

Attendant Services Program

Goal: #1, 2 and 3

The Attendant Services Program supports independent living by providing in-home personal care to individuals with disabilities, including both older Vermonters and younger adults. The funding for this program has increased incrementally over recent years, resulting in a SFY 2002 current general fund budget of \$3.6 million. As of May, 2002, the program served 248 individuals, 98 of whom were over age 60. The average age of participants was 55 years.

The recent creation of Medicaid Participant-Directed Attendant Care will improve access for those people who have permanent and severe disabilities, are eligible for Medicaid, and can direct their own care. Those applicants who do not meet these eligibility criteria, however, are likely to wait for years before funding is available to meet their needs.

Objectives

1. Increase the availability of paid caregivers by improving wages, benefits, and working conditions.
2. Improve the ability of consumers to manage their own services by providing training in consumer-direction skills.

Homemaker, Chore and Personal Care Assistance Services

Goals: #1, 2, 3 and 5

Homemaker services are an important piece of Vermont's independent living service system, enabling many older people to remain at home in a safe and healthy environment. During FFY 2001, 356 units of such assistance were provided by the AAAs under the OAA, utilizing \$4,883 in Title III funds.

In addition to OAA funded services, the Department contracts with Home Health Agencies statewide to provide Homemaker services, supporting their efforts with a combination of state General Funds and federal Social Services Block Grant funds. In

SFY 2001, approximately 750 people were served through Home Health Agency Homemaker programs, using a total of \$825,000 in funding. As with the Medicaid Waiver program, AAA case management staff provide support to a high percentage of these individuals through referral, case follow up and related services.

The AAA's ability to collaborate with local Home Health Agencies is an important factor in the success of these programs. There is no question that such assistance makes a significant difference in the lives of the most frail of the aging population. Assessment data reveal that many recipients are old (i.e. age 85 and older), live alone, and have very limited financial resources. Access to these home care services plays an important role in supporting independent living for those who are served.

Objectives

1. Improve the capacity of local agencies to coordinate funding requests, identify priority needs, and effectively manage funding to maximize access and positive client outcomes.
2. In anticipation of level funding, AAA will provide 356 units of service provided per year.

Senior Volunteer Programs

Goal: #1, 3 and 5

The Department maintains a commitment to support programs that can provide opportunities for volunteer service in order to provide elders with opportunities to fully engage in life and promote successful aging. At present, we provide resources, receive funding and/or serve as a pass through for federal and state funds, which support these opportunities.

The Vermont Senior Companion Program was established in 1981. The program is sponsored by the Central Vermont Council on Aging, which contracts with the five Area Agencies on Aging to coordinate this service initiative for people age 60. Senior Companions provide assistance and friendship to elders who are alone and/or homebound. The companions meet income guidelines and serve 20 hours per week to receive a stipend and mileage reimbursement. The Department contributes general fund dollars annually to support this program. In 2001, Vermont Senior Companions drove 204,840 miles to spend 63,693 hours visiting 584 elders. The Senior Companion Program brings "the outside world inside" to Vermont elders whose greatest wish is to remain independent in their own homes for as long as possible.

The Foster Grandparent Program provides low-income elders the opportunity to serve children and adolescents in their communities by working with them up to 20 hours per week for a small stipend and mileage reimbursement. There are two Foster Grandparent Programs in the state covering Chittenden, Franklin, Grand Isle, Washington, Rutland, Addison, and Bennington Counties. 144 volunteers served 2,282 children in 58 agencies

providing 105,368 hours of service in SFY 2001. The Department contributes general fund dollars support this program.

RSVP: An Invitation to Serve: RSVP is part of a national program that provides volunteer opportunities for people age 55 and over. There are six projects located throughout Vermont. Those projects tap into the talents and skills of volunteers to assist individuals and nonprofit organizations that are responding to community needs. RSVP provides volunteers with supplemental insurance, information on specific volunteer opportunities, a members' newsletter, as well as support, feedback and recognition of their work. Examples of what RSVP volunteers are doing in Vermont include:

- Helping students succeed in school by working as tutors and mentors;
- Supporting frail elders and people with disabilities to live independently by driving them to appointments, delivering meals, and just visiting;
- Assisting individuals in tax preparation;
- Helping adult learners to attain their GED's; and
- Working with individuals who are incarcerated.

In SFY 2001, 3,939 RSVP volunteers served in 884 agencies and provided 408,567 hours of service throughout the state. Funding from the legislature is passed through the Department of Aging and Disabilities.

Objectives

1. Continue to support opportunities for Vermont elders to access volunteer opportunities to which support elders to fully engage in life and promote successful aging.
2. Maintain a collaborative working relationship with the existing network of volunteer programs which support elders to ensure an effective state response to changing state demographics.

Older American Senior Community Service Employment Program

Goals: #1 and 5

The Older American Senior Community Service Employment Program provides employment and training as well as community service opportunities for elders. The Department of Aging & Disabilities serves as the pass through for Vermont Associates for Training and Development, Inc., which is the designated agency to administer the Community Service Employment Program funded under Title V of the OAA. In recent years the Department has funded 59 training positions through Vermont Associates a private non-profit corporation which specializes in the design and operation of employment and training services exclusively for the 55 plus population. To date, Vermont Associates has served over 7,000 Vermonters in its various OAA funded programs. The OACSEP, offered by Vermont Associates through its statewide network of 12 training centers throughout the state, provides part-time community service

employment to low-income individuals age 55 and older and assists them in obtaining unsubsidized employment.

Vermont Associates, through partnerships with public and private non-profit agencies, places program participants in local communities for on-the-job training. While training, these participants provide needed community services for the agencies in which they are placed. The agency gains the help it needs and the participants gain the skills and experience they need to be successful in today's competitive job market.

Program participants must be Vermont residents, income eligible, and age 55 or over. They train 20 hours per week and receive a training stipend while in training.

Objectives

1. Continue to support opportunities for Vermont elders to access work-related opportunities.
2. Maintain a collaborative working relationship with the existing network of work-related programs which support elders to ensure an effective state response to changing state demographics.

State Health Insurance Assistance Program (SHIP)

Goals: #1, 3, 5

For a number of years the Department has been the grantee for a Centers for Medicare and Medicaid Services (CMS) program intended to provide information, education and assistance to older Vermonters coping with the complexities of Medicare and other insurance programs. The program has operated on a regional basis with local AAAs providing staff coordination of the program that includes volunteer recruitment and training among its goals. With both staff and a volunteer network the state's ability to reach a broader cross section of elders in need is expanded. This is an exceptionally important resource for many older individuals.

The Department continues to contract with Northeastern Vermont Area Agency on Aging (NEVAAA) to provide administrative oversight and direct supervision of AAA and/or other program grantees.

The number of Vermont elders receiving direct assistance from SHIP has increased from 16,497 in 1999-2000 to 21,607 beneficiaries from March of 2001 through March of 2002.

In the fall of 2001, the Vermont Beneficiaries Workgroup (a coalition of health care organizations and agencies working together to provide Vermonters with more, and better organized, access to Medicare information and resources) provided a series of presentations on health-related issues for elders. These presentations were held in all 14 acute care hospitals throughout the state. This was the second year in which such presentations were held.

SHIP partnered with interested partners such as those from the Medicare Fiscal Intermediary, the Medicare Carrier, the Social Security Administration, the Medicare Peer Review Organization, and the Vermont Bank, Insurance, Securities and Health Care Administration (BISHCA). During the presentations, SHIP offered special sessions for health care providers, as well as Vermont Medicare beneficiaries, many of whom are socially and geographically isolated. During this series of outreach efforts, SHIP was able to make packets of Medicare-related information available to over 550 participants.

Objectives

1. Continue to increase outreach capabilities for Medicare beneficiaries.
2. Recruit and train new volunteers.
3. Continue to strengthen partnerships with state and local agencies, to enhance available resources.
4. Expand the SHIP website.
5. Work with the 191 libraries in Vermont, which have been identified as an accessible route for beneficiaries to use in obtaining Medicare and other medically related insurance information. In addition, approximately one-half of Vermont libraries are automated. SHIP is taking advantage of the vital access to information that these libraries can offer to their patrons by teaching staff about the important issues affecting people with Medicare. Along with information packets, libraries are able to offer beneficiaries instruction on how to reach the local and national SHIP websites, for in-depth Medicare benefits information.

Neighbor-to-Neighbor Program

Goals: #1, 3, 5

Neighbor-to-Neighbor is a statewide AmeriCorps program that promotes independence for elders and adults with disabilities by supporting relationships in which elders are a valued community asset, receive the support they need to live at home, and have access to programs that enable successful aging. The program is sponsored by the Central Vermont Council on Aging; and twenty-five members are placed throughout each of the five Area Agencies on Aging for a one year term of service. The Department contributes \$120,000 state general fund dollars annually to help cover a portion of the match required from the Corporation of National and Community Service. The annual grant budget of the Neighbor-to-Neighbor AmeriCorps program is \$460,000.

Neighbor-to-Neighbor promotes "successful aging" for elders by helping elders remain healthy and mobile, develop a sense of worth, and maintain physical and spiritual well-being. Members will work with community and senior centers to develop programs that will promote successful aging including exercise classes, art classes, and educational classes.

Neighbor-to-Neighbor also actively supports intergenerational programs between youth and elders in the community by partnering elders with youth volunteers. The youth

volunteers make weekly reassurance phone calls, organize and teach games, learn new crafts, and help prepare and elder's home for the winter. Many elders act as mentors for youth who do not have grandparents living nearby.

AmeriCorps members work independently or on teams of three to six throughout the state of Vermont. Neighbor-to-Neighbor members balance their time between providing direct service to elders and adults with disabilities and recruiting volunteers to meet the needs of clients.

For the 2000-2001 program year, Neighbor to Neighbor program highlights include:

- 4,000 elders and adults with disabilities participated in 201 successful aging initiatives
- 1,500 elders and adults with disabilities were provided direct service by members or volunteers
- 1,300 adults and youth volunteered their time to elders and adults with disabilities
- 9,400 hours of volunteer hours accumulated

SUMMARY PUBLIC HEARING AND COMMENT PROCESS

The preparation and research, which led to the development of Vermont's State Plan on Aging, consisted of several steps designed to solicit input from the maximum number of people and organizations. The goal was to ensure that the Department heard from a broad constituency.

As the first step, planning meetings to coordinate State and Area Plan development took place throughout the fall and winter, 2001 – 2002. Discussions occurred between the Department and AAA at regular monthly meetings of the AAA Executive Directors and at special meetings involving additional AAA staff and Governing Board members. On April 24, 2002, the Department issued AAA Area Plan Instructions for Federal Years 2003 – 2005. The instructions require a uniform format for AAA to use in developing and submitting the Area Plans for State review and approval. The State Plan is based in part on the AAA Area Plans, using the information, meetings and other discussions that occurred over the course of the year.

As the second step, the Department issued an invitation to 245 organizations and individuals with an interest in aging to provide input into the needs, issues, concerns and goals for the future. The Department received feedback from 13 organizations and individuals including: 5 senior centers, 1 Area Agency on Aging, 1 State Representative, 2 public transportation providers, the Vermont Public Transportation Association, a representative of the Elder Services Task Force of the Deerfield Valley, the State Coalition on Substance Abuse and Older Vermonters and one professional caregiver. In addition, the Department consulted with the Department of Aging and Disabilities' Advisory Board, the Community of Vermont Elders (COVE), the State Coalition on Substance Abuse and Older Vermonters and held regular discussions with the Area Agencies on Aging to coordinate the Area Planning and State Planning process. Whenever possible, the input and suggestions were incorporated into the Draft State Plan.

The third step involved the distribution of the Draft State Plan to over 373 individuals and organizations. Formal public hearings were held on July 16, 2002 in Berlin and on July 17, 2002 in Rutland. A total of seven individuals attended the public hearings, representing COVE, AARP, one public transportation provider, a private citizen/public transportation driver and the Southwestern Vermont Council on Aging. No attendees at the public hearings offered formal public comments. Written comments were received from the Champlain Valley Agency on Aging, the Council on Aging for Southeastern Vermont, the RSVP Directors' Association, COVE, the Foster Grandparent Program, the Department of Developmental and Mental Health Services and one private citizen. In addition, a follow-up meeting was held with the Department's Advisory Board. Finally, a copy of the Draft was provided to the Administration on Aging for initial review. When appropriate, changes were made to the Final Draft State Plan to incorporate the suggestions and comments received. General response to the Draft State Plan was positive. Although not a complete outline of all comments, the following is a summary of the most common issues raised:

COMMENTS

- Members of the Department's Advisory Board, the Council on Aging for Southeastern Vermont and a regional representative of the Administration on Aging commented on the value to be gained by including outcome measures for the State Plan goals. The Department agrees and has included outcome measures in the Final Draft.
- Representatives from senior centers across the state commented that the Department should directly contract for services with them and should find additional resources to support them to develop their organizations as broad-based community resources for elders. Senior centers pointed out the on-going financial challenges of retaining qualified staff and maintaining aging buildings. The Department values the important contribution that Vermont's senior centers and meal sites make to the lives of Vermont elders. Many of these programs receive funding through the AAAs which contract for OAA nutrition services as well as health promotion and disease prevention services, as part of the OAA or through the SAIL initiative. At this time, there are no additional funds available at the Department level to provide direct funding to this network of providers.
- The lack of public transportation and the need for accessible transportation/assisted transportation was noted by many as a continuing need that has a direct impact on elders' abilities to access needed community services and to remain independent. The Department concurs that transportation is a continuing unmet need in most areas and will continue to work with VTrans, the aging network and the public transit providers to seek ways to improve the system for elders.
- Two private citizens shared their experiences and/or insights into the needs of elders, with a particular emphasis on: the impact that health and community connections plays in the mental health and overall well-being of elders, the importance of quality hospital discharge planning and the need for adequate community resources to prevent premature nursing home placement.
- The Vermont Assembly of Home Health Agencies (VAHHA) cautioned that further expansion of the Medicaid Waiver programs should be based on an analysis of the capacity of service providers to meet the need. The data that will be available from the Department's system-wide capacity study will be helpful in analyzing capacity and planning to meet future needs. VAHHA also requested that they be consulted in the development of any plans to introduce community ombudsman services.
- The Champlain Valley Agency on Aging cautioned against making any changes in the funding formula that would reduce funding going to high need areas; and later requested clarification about whether non-institutionalized people are included in either the 125% of poverty or old, alone and poor figures. The Department researched the issue and determined that those data are not available for this population and that those data will not be available from the 2000 Census.

Furthermore, prior to publishing the Draft State Plan and funding formula, the Department consulted with the five AAAs. The parties agreed that no changes to the present funding formula would be made at this time.

- A representative from COVE suggested adding some acknowledgement of the contribution that community hospitals make to lead and coordinate efforts to meet the preventive and/or successful aging needs of elders. This acknowledgement was added to the Final Draft of the State Plan.
- Representatives from COVE and AARP shared their concern about the rising cost of prescription medications; and identified the need to support family caregivers, including grandparents, and concerns regarding the security of elders' retirement investments as areas of growing interest by the elder community.
- The Foster Grandparent Program and RSVP offered very helpful suggestions to better distinguish employment programs from volunteer programs and to highlight the many benefits of volunteer programs. The majority of the suggestions have been incorporated into the Final Draft.

**POPULATION DATA AND 'OLD, ALONE AND POOR'
DATA FOR SELECTED AAA SERVICE AREA by ELDERLY AGE GROUPS**

AAA	60+ Population by AAA Region
Central Vermont	19,349
Champlain Valley	31,559
Northeastern Vermont	11,920
Southeastern Vermont	19,305
Southwestern Vermont	19,694
Total	101,827

AAA	Old, Alone and Poor
Central Vermont	785.22
Champlain Valley	1078.84
Northeastern Vermont	543.14
Southeastern Vermont	693.85
Southwestern Vermont	710.51
Total	3811.55

Note: Population cohorts for the 60 and Over Age category are based on the 2000 Census. Population cohorts for the Old, Alone and Poor category (OAP) are estimated based on detailed economic and demographic data from the 1990 Census. Specifically, the 1990 Census data for Old, Alone and Poor are projected forward based on the 10 year growth in the Age 75 and Over cohort between the 1990 Census and the 2000 Census. Detailed economic and demographic data necessary to make the OAP tabulations will not be available from the 2000 Census until the summer/fall of 2002.

Method of Distribution for Title III and State Funding

There are four steps in the distribution process of Older Americans Act and state funding to the Area Agencies on Aging. These include:

1. Base distribution of \$425,220 is divided equally among the AAA (\$85,044 per AAA).
2. Calculation of remaining funds includes weighting of factors related to social need (OAP), numbers of aged 60 and over and economic need.
 - One-third of the funds are distributed according to age;
 - 80% of the remaining two-thirds is distributed using the OAP formula;
 - 20% of the remaining two-thirds is distributed according to the number of individuals below 125% of poverty.
3. Social need calculation based on population cohort age 75+ living alone and below the poverty line (OAP) in each AAA region.
4. Economic need based on population cohort 60+ below 125% of poverty and not OAP (Pov 125) in each AAA region.

Funding Formula Factors

Listed below is the State distribution of the Old, Alone and Poor (OAP) and Pov125 population cohorts.

Population cohorts for the 60 and Over Age category are based on the 2000 Census.

Population cohorts for the Old, Alone and Poor category (OAP) are estimated based on detailed economic and demographic data from the 1990 Census. Specifically, the 1990 Census data for Old Alone and Poor are projected forward based on the 10- year growth in the Age 75 and Over cohort between the 1990 Census and the 2000 Census. Detailed economic and demographic data necessary to make the OAP tabulations will not be available from the 2000 Census until the summer/fall of 2002.

Population cohorts for the Pov125 category are estimated based on detailed economic and demographic data from the 1990 Census. Specifically, the 1990 Census data for Pov125 are projected forward based on the 10-year growth in the Age 60 and Over cohort between the 1990 Census and the 2000 Census. Detailed economic and demographic data necessary to make the Pov125 tabulations will not be available from the 2000 Census until the summer/fall of 2002.

These are the age 60 and over factors (Age):

Area	Population	Factor (% of State)
Central	19,349	19.00184%
Champlain	31,559	30.99276%
Northeast	11,920	11.70613%
Southeast	19,305	18.95863%
Southwest	19,694	19.34065%
Total	101,827	

These are the Old, Alone and Poor Factors (OAP):

Area	Population	Factor (% of State)
Central	785.22	20.60093
Champlain	1078.84	28.30445
Northeast	543.14	14.24989
Southeast	693.85	18.20389
Southwest	710.51	18.64084
Total	3811.55	

These are the age 60 and over, below 125% of Poverty, not the OAP Factors (Pov 125%)

Area	Population	Factor (% of State)
Central	2840.31	19.43613
Champlain	4384.44	30.00249
Northeast	2133.03	14.59623
Southeast	2737.42	18.73202
Southwest	2518.38	17.23313
Total	14613.58	

OLDER AMERICANS ACT ALLOCATIONS TO AREA AGENCIES ON AGING

RESOURCE PROJECTIONS FOR 2003 BASED ON ESTIMATED FUNDING

	<u>CENTRAL</u>	<u>CHAMPLAIN</u>	<u>NORTHEAST</u>	<u>SOUTHEAST</u>	<u>SOUTHWEST</u>	<u>TOTAL</u>
TITLE III and VII						
SERVICE BASE	85,044	85,044	85,044	85,044	85,044	425,220
SUPPORTIVE SERVICES	752,178	1,111,832	507,998	699,980	706,227	3,778,215
SUB-TOTAL SERVICES	837,222	1,196,876	593,042	785,024	791,271	4,203,435
AREA PLAN						
ADMINISTRATION	99,748	99,748	99,748	99,748	99,748	498,740
NET TITLE III and VII	936,970	1,296,624	692,790	884,772	891,019	4,702,175
STATE GENERAL FUND	279,793	413,576	188,963	260,376	262,700	1,405,408
STATE TRANS. FUND	82,022	121,241	55,395	76,330	77,011	411,999
SPECIAL SERVICES FUND	4,869	6,693	3,368	4,305	4,410	23,645
ENERGY	15,000	15,000	15,000	15,000	15,000	75,000
FOOD STAMP OUTREACH	43,669	66,054	24,806	29,019	40,604	204,152
MEDICAID ADMIN (ELIGIBILITY)	29,862	44,141	20,170	27,790	28,037	150,000
ALZHEIMER FUND	92,159	150,315	56,775	91,949	0	391,198
ST GEN FUND TRANS TO DMH	49,771	73,568	33,614	46,317	46,730	250,000
<u>USDA/NSIP</u>	<u>108,722</u>	<u>149,007</u>	<u>74,095</u>	<u>121,807</u>	<u>119,541</u>	<u>573,172</u>
TOTAL	1,642,837	2,336,219	1,164,976	1,557,665	1,485,052	8,186,749

Title III and VII funds are based upon the FFY02 Title III awards to the State.

Food Stamp Outreach allocation is projected according to time study. Actual earnings are subject to availability of Federal funds and DAD/PATH agreement.

Title III and related resources are based on 2000 census.

Estimates were used for poverty rates, household composition status, and 125% poverty as this detail is not currently available from the 2000 census.

USDA uses current allocation that will be adjusted for FY02 meals

AAA FFY03 Allocation

	Total	Central	Champlain	North East	South East	South West	Total
Area Plan Administration	498,742	99,748	99,748	99,748	99,748	99,748	498,740
Service base	425,220	85,044	85,044	85,044	85,044	85,044	425,220
Age	1,259,404	239,310	390,324	147,427	238,766	243,577	1,259,404
OAP	2,015,048	414,956	570,365	287,033	366,853	375,839	2,015,046
POV125	503,765	97,912	151,143	73,538	94,361	86,811	503,765
Total Title III	4,702,179	936,970	1,296,624	692,790	884,772	891,019	4,702,175 4,702,175
Elder Abuse	0.00551	5,162	7,141	3,816	4,873	4,907	25,899
Preventive Health	0.02224	20,835	28,832	15,405	19,674	19,813	104,559
Title III-B	0.32826	307,570	425,630	227,415	290,435	292,486	1,543,535
Title III-C1	0.32218	301,877	417,752	223,207	285,060	287,072	1,514,969
Title III-C2	0.18580	174,091	240,916	128,722	164,392	165,554	873,674
Title III-E	0.13601	127,437	176,353	94,226	120,337	121,187	639,540
Total	1.00000	936,972	1,296,624	692,791	884,771	891,019	4,702,176 4,702,177
GENERAL FUNDS		279,793	413,576	188,963	260,376	262,700	1,405,408
NUTRITION		0	0	0	0	0	0
MENTAL HEALTH		<u>49,771</u>	<u>73,568</u>	<u>33,614</u>	<u>46,317</u>	<u>46,730</u>	<u>250,000</u>
		329,564	487,144	222,577	306,693	309,430	1,655,408

VERMONT

State Agency on Aging

Department of Aging and Disabilities

103 South Main Street
Waterbury, VT 05671-2301
Commissioner: Patrick Flood
Phone: (802) 241-2400
Fax: (802) 241-2325
TTY: (802) 241-3557
Web site: www.dad.state.vt.us

Area Agencies on Aging

**STATEWIDE INFORMATION & ASSISTANCE:
SENIOR HELPLINE: 1-800-642-5119**

Central Vermont Council on Aging

30 Washington Street
Barre, VT 05641
Director: Charles Castle
Phone: (802) 479-0531
Fax: (802) 479-4235

Champlain Valley Agency on Aging

P.O. Box 158
Winooski, VT 05404
Director: John Barbour
Phone: (802) 865-0360
Fax: (802) 865-0363
Web site: www.cvaa.org

Council on Aging for Southeastern Vermont

56 Main Street, Suite 304
Springfield, VT 05156
Director: Marie Saunders
Phone: (802) 885-2655
Fax: (802) 885-2665
Web site: www.coasevt.org

Northeastern Vermont Area Agency on Aging

1161 Portland Street
St. Johnsbury, VT 05819
Director: Monica Holcomb, Acting Dir.
Phone: (802) 748-5182
Fax: (802) 748-6622

Southwestern Vermont Council on Aging

East Ridge Professional Building
1085 U.S. Route 4 East, Unit 2B
Rutland, VT 05701
Director: Diane Novak
Phone: (802) 786-5991
Fax: (802) 786-5994

OLDER AMERICANS ACT AS AMENDED 2000
STATE PLAN ASSURANCES AND PROVISIONS

Section. 305, ORGANIZATION

- (1) 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)(A))
- (2) 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)(B))
- (3) 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 minority individuals and older individuals residing in rural areas and include proposed methods of carrying out the preference in the State plan. ((a)(2)(E))
- (4) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16). ((a)(2)(F))
- (5) 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. ((a)(2)(G)(H))
- (6) 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. ((c)(5))

Section 306, AREA PLANS

- (1) 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, outreach, information and assistance, 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. ((a)(2))

(2) Each area agency on aging shall provide assurances that the area agency on aging will set specific objectives for providing services to older individuals with greatest economic need and older individuals with greatest social need, include specific objectives for providing services to low income minority individuals and older individuals residing in rural areas, and include proposed methods of carrying out the preference in the area plan. ((a)(4)(A)(i))

(3) Each area agency on aging shall 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

- (A) specify how the provider intends to satisfy the service needs of low income minority individuals and older individuals residing in rural areas in the area served by the provider;

- (B) to the maximum extent feasible, provide services to low income minority individuals and older individuals residing in rural areas in accordance with their need for such services; and

- (C) meet specific objectives established by the area agency on aging, for providing services to low income minority individuals and older individuals residing in rural areas within the planning and service area. ((a)(4)(ii))

(4) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall

- (A) identify the number of low income minority older individuals and older individuals residing in rural areas in the planning and service area;

- (B) describe the methods used to satisfy the service needs of such minority older individuals; and

(C) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i). ((a)(4)(A)(iii))

(5) 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

- (A) older individuals residing in rural areas;
- (B) older individuals with greatest economic need (with particular attention to low income minority individuals and older individuals residing in rural areas);
- (C) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
- (D) older individuals with severe disabilities;
- (E) older individuals with limited English speaking ability; and
- (F) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals);

and inform the older individuals referred to in (A) through (F), and the caretakers of such individuals, of the availability of such assistance. ((a)(4)(B))

(6) 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. ((a)(4)(C))

(7) 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, with agencies that develop or provide services for individuals with disabilities. ((a)(5))

(8) 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. ((a)(9))

(9) 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. ((a)(11))

(10) 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. ((a)(13)(A))

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

- (A) 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
- (B) the nature of such contract or such relationship. ((a)(13)(B))

(12) 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 nongovernmental contracts or such commercial relationships. ((a)(13)(C))

(13) 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 nongovernmental contracts or commercial relationships. ((a)(13)(D))

(14) 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.
((a)(13)(E))

(15) 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. ((a)(14))

(16) Each area agency on aging shall provide assurances that preference in receiving services under this title will not be given by the area agency on aging to particular older individuals as a result of a contract or commercial relationship that is not carried out to implement this title. ((a)(15))

Sec. 307, STATE PLANS

(1) The plan shall provide assurances that -

(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; ((a)(1)(A)) and

(B) the State plan is based on such area plans. ((a)(1)(B))

(2) The plan provides assurances that the State agency -

(A) evaluates, using uniform procedures described in section 202(a)(29), 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; ((a)(2)(A)) and

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including volunteers and programs and services of voluntary organizations) have the capacity and actually meet such need; ((a)(2)(B))

(3) With respect to services for older individuals residing in rural areas, the State agency

(A) assures it will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000; and

(B) The plan describes the methods used to meet the need for services to older persons residing in rural areas in the fiscal year preceding the first year to which this plan applies. The description is found on page(s) 7 – 8 and 35 -62 of this plan. ((a)(3)(B)(iii))

(4) The plan shall provide satisfactory assurance that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under titles III and 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 individuals and older individuals residing in rural areas. ((a)(4))

(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 an 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 316. ((a)(5))

(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. ((a)(6))

(7) 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. ((a)(7)(A))

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

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

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

(C) such services can be provided more economically, and with comparable quality, by the State agency or area agency on aging. ((a)(8)(A))

(9) The plan shall provide assurances that

(A) 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;

(B) 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

(C) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act. ((a)(7)(B))

(10) 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. ((a)(9))

(11) 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. ((a)(10))

(12) The plan shall provide assurances that Area Agencies on Aging will--

(A) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(B) 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

(C) 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. ((a)(11)(A))

(13) 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. ((a)(11)(B))

(14) 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; ((a)(11)(D)).

(15) 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. ((a)(11)(E))

(16) 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. ((a)(12))

(17) 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. ((a)(13))

(18) 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 fulltime 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.

((a)(14))

(19) The plan shall provide assurances that the State agency will require outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on--

(A) older individuals residing in rural areas;

(B) older individuals with greatest economic need (with particular attention to low income minority individuals and older individuals residing in rural areas);

(C) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(D) older individuals with severe disabilities;

(E) older individuals with limited English speaking ability; and

(F) older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and inform the older individuals referred to in clauses (A) through (F) and the caretakers of such individuals, of the availability of such assistance.

((a)(16))

(20) 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. ((a)(17))

(21) 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. ((a)(18))

(22) The plan shall include the assurances and description required by section 705(a). ((a)(19))

(23) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services. ((a)(20))

(24) 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. ((a)(21))

(25) 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). ((a)(22))

(26) 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.

((a)(23))

(27) 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. ((a)(24))

(28) 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. ((a)(25))

(29) 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. ((a)(26))

Section 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(1) 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. ((b)(3)(E))

Section 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.

ENDNOTES

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