

## **Balancing the System:**

### ***Working Towards Real Choice for Long-Term Care in Connecticut***

**A Report to the General Assembly  
January 2007**

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## APPENDIX A.

### Authorizing Statute for the Long-Term Care Planning Committee and the Long-Term Care Advisory Council

#### CONNECTICUT GENERAL STATUTES TITLE 17B. SOCIAL SERVICES CHAPTER 319Y. LONG-TERM CARE

##### **§ 17b-337. Long-term elderly care planning committee. Long-term care plan for elderly persons. Membership**

(a) There shall be established a Long-Term Care Planning Committee for the purpose of exchanging information on long-term care issues, coordinating policy development and establishing a long-term care plan for all persons in need of long-term care. Such policy and plan shall provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting. Such plan shall integrate the three components of a long-term care system including home and community-based services, supportive housing arrangements and nursing facilities. Such plan shall include: (1) A vision and mission statement for a long-term care system; (2) the current number of persons receiving services; (3) demographic data concerning such persons by service type; (4) the current aggregate cost of such system of services; (5) forecasts of future demand for services; (6) the type of services available and the amount of funds necessary to meet the demand; (7) projected costs for programs associated with such system; (8) strategies to promote the partnership for long-term care program; (9) resources necessary to accomplish goals for the future; (10) funding sources available; and (11) the number and types of providers needed to deliver services. The plan shall address how changes in one component of such long-term care system impact other components of such system.

(b) The Long-Term Care Planning Committee shall, within available appropriations, study issues relative to long-term care including, but not limited to, the case-mix system of Medicaid reimbursement, community-based service options, access to long-term care and geriatric psychiatric services. The committee shall evaluate issues relative to long-term care in light of the United States Supreme Court decision, *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999), requiring states to place persons with disabilities in community settings rather than in institutions when such placement is appropriate, the transfer to a less restrictive setting is not opposed by such persons and such placement can be reasonably accommodated.

(c) The Long-Term Care Planning Committee shall consist of: (1) The chairpersons and ranking members of the joint standing and select committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care; (2) the Commissioner of Social Services, or the commissioner's designee; (3) one member of the Office of Policy and Management

appointed by the Secretary of the Office of Policy and Management; (4) one member from the Department of Social Services appointed by the Commissioner of Social Services; (5) one member from the Department of Public Health appointed by the Commissioner of Public Health; (6) one member from the Department of Economic and Community Development appointed by the Commissioner of Economic and Community Development; (7) one member from the Office of Health Care Access appointed by the Commissioner of Health Care Access; (8) one member from the Department of Mental Retardation appointed by the Commissioner of Mental Retardation; (9) one member from the Department of Mental Health and Addiction Services appointed by the Commissioner of Mental Health and Addiction Services; (10) one member from the Department of Transportation appointed by the Commissioner of Transportation; (11) one member from the Department of Children and Families appointed by the Commissioner of Children and Families; and (12) the executive director of the Office of Protection and Advocacy for Persons with Disabilities or the executive director's designee. The committee shall convene no later than ninety days after June 4, 1998. Any vacancy shall be filled by the appointing authority. The chairperson shall be elected from among the members of the committee. The committee shall seek the advice and participation of any person, organization or state or federal agency it deems necessary to carry out the provisions of this section.

(d) Not later than January 1, 1999, and every three years thereafter, the Long-Term Care Planning Committee shall submit a long-term care plan pursuant to subsection (a) of this section to the joint standing and select committees of the General Assembly having cognizance of matters relating to human services, public health, elderly services and long-term care, in accordance with the provisions of section 11-4a, and such plan shall serve as a guide for the actions of state agencies in developing and modifying programs that serve persons in need of long-term care.

(e) Any state agency, when developing or modifying any program that, in whole or in part, provides assistance or support to persons with long-term care needs, shall, to the maximum extent feasible, include provisions that support care-giving provided by family members and other informal caregivers and promote consumer-directed care.

### **§ 17b-338. Long-Term Care Advisory Council. Membership. Duties**

(a) There is established a Long-Term Care Advisory Council which shall consist of the following: (1) The executive director of the Commission on Aging, or the executive director's designee; (2) the State Nursing Home Ombudsman, or the ombudsman's designee; (3) the president of the Coalition of Presidents of Resident Councils, or the president's designee; (4) the executive director of the Legal Assistance Resource Center of Connecticut, or the executive director's designee; (5) the state president of AARP, or the president's designee; (6) one representative of a bargaining unit for health care employees, appointed by the president of the bargaining unit; (7) the president of the Connecticut Association of Not-For-Profit Providers for the Aging, or the president's designee; (8) the president of the Connecticut Association of Health Care

Facilities, or the president's designee; (9) the president of the Connecticut Association of Residential Care Homes, or the president's designee; (10) the president of the Connecticut Hospital Association or the president's designee; (11) the executive director of the Connecticut Assisted Living Association or the executive director's designee; (12) the executive director of the Connecticut Association for Homecare or the executive director's designee; (13) the president of Connecticut Community Care, Inc. or the president's designee; (14) one member of the Connecticut Association of Area Agencies on Aging appointed by the agency; (15) the president of the Connecticut chapter of the Connecticut Alzheimer's Association; (16) one member of the Connecticut Association of Adult Day Centers appointed by the association; (17) the president of the Connecticut Chapter of the American College of Health Care Administrators, or the president's designee; (18) the president of the Connecticut Council for Persons with Disabilities, or the president's designee; (19) the president of the Connecticut Association of Community Action Agencies, or the president's designee; (20) a personal care attendant appointed by the speaker of the House of Representatives; (21) the president of the Family Support Council, or the president's designee; (22) a person who, in a home setting, cares for a person with a disability and is appointed by the president pro tempore of the Senate; (23) three persons with a disability appointed one each by the majority leader of the House of Representatives, the majority leader of the Senate and the minority leader of the House of Representatives; (24) a legislator who is a member of the Long-Term Care Planning Committee; and (25) one member who is a nonunion home health aide appointed by the minority leader of the Senate.

(b) The council shall advise and make recommendations to the Long-Term Care Planning Committee established under > section 17b-337.

(c) The Long-Term Care Advisory Council shall seek recommendations from persons with disabilities or persons receiving long-term care services who reflect the socio-economic diversity of the state.

# **APPENDIX B.**

## **Long-Term Care Planning Committee Membership**

**(as of December 31, 2006)**

### **Legislators**

Senator Jonathan Harris, Co-Chair, Select Committee on Aging  
Representative Art Feltman, Co-Chair, Select Committee on Aging  
Senator John A. Kissel, Ranking Member, Select Committee on Aging and Human Services Committee  
Representative Alfred Adinolfi, Ranking Member, Select Committee on Aging  
Senator Christopher S. Murphy, Co-Chair, Public Health Committee  
Representative Peggy Sayers, Co-Chair, Public Health Committee  
Senator George L. Gunther, Ranking Member, Public Health Committee  
Representative Julia B. Wasserman, Ranking Member, Public Health Committee  
Senator Mary Ann Handley, Co-Chair, Human Services Committee  
Representative Peter F. Villano, Co-Chair, Human Services Committee  
Representative Lile R. Gibbons, Ranking Member, Human Services Committee

### **State Agencies Representatives**

David Guttchen, Office of Policy and Management (Chair of Planning Committee)  
Kathy Bruni, Department of Social Services  
Tom Ciccalone, Department of Economic and Community Development  
Joan Leavitt, Department of Public Health  
Pam Giannini, Department of Social Services  
Jennifer Glick, Department of Mental Health and Addiction Services  
Beth Leslie, Office of Protection and Advocacy for Persons with Disabilities  
Robert Plant, Department of Children and Families  
Rick Robbins, Department of Economic and Community Development  
Michael Sanders, Department of Transportation  
Laura Nuss, Department of Mental Retardation  
Vacant, Office of Health Care Access

### **Staff**

Barbara Parks Wolf, Office of Policy and Management

### **Former Committee Participants**

Michele Parsons, Department of Social Services

## APPENDIX C.

### Long-Term Care Advisory Council Membership

<u>Organization</u>	<u>Representative</u>
Legislative Member	Representative Peter F. Villano (Co-chair)
CT Commission on Aging	Julia Evans Starr (Co-Chair)
CT Association of Residential Care Homes	Marge Anderson
Personal Care Attendant	Debbie Legault
CT Association of Area Agencies on Aging	Kate McEvoy
CT Council for Persons with Disabilities	Midred Blotney
CT Association of Health Care Facilities	Richard Brown
CT Assisted Living Association	Christopher Carter
CT Association of Adult Day Care	Holly Vannucci
Bargaining Unit for Health Care Employees/ 1199 AFL-CIO	Deborah Chernoff
CT Family Support Council	Laura Knapp
Consumer	Michelle Duprey
AARP – CT	Brenda Kelley
CT Association of Home Care, Inc.	Brian Ellsworth
CT LTC Ombudsman Program	Nancy Shaffer & Margaret Ewald
Legal Assistance Resource Center	Joelen Gates
CT Community Care, Inc.	Molly Rees Gavin
CT Hospital Association	Jennifer Jackson
CRT/CT Assoc. of Community Action Agencies	Vacant
CT Alzheimer’s Association	Joe Ierna
CANPFA	Margaret Morelli
Family Caregiver	Susan Raimondo
CT Coalition of Presidents of Resident Councils	Tom Molway
American College of Health Care Administrators	George Giblin
Consumer	Kenneth Harrington-Howes
Consumer	Sue Pedersen
Nonunion Home Health Aide	Vacant

#### Friends of the Advisory Council

Quincy Abbot, ARC/CT  
 Bill Eddy, Commission on Aging Member  
 Christianne Kovel, Hebrew Home and Health Care  
 Mary-Ann Langton, CT Council on Developmental Disabilities  
 Cathy Ludlum  
 Gloria McKenna, Select Committee on Aging  
 Stacey Walker, CT Association of Resident Services Coordinators in Housing

## **APPENDIX D.**

### **Sources of Public Comment**

The Long-Term Care Advisory Council assumed responsibility for seeking and gathering broad public input on the 2007 Long-Term Care Plan. In October and December of 2006 and again in January 2007, drafts of the Plan were distributed to diverse organizations and individuals throughout Connecticut with an interest in long-term care. Public comments were received from the following individuals and organizations.<sup>1</sup>

- AARP Connecticut – Brenda Kelly, State Director; Claudio Gualtieri, Program Coordinator; John Erlingheuser
- Agency on Aging of South Central Connecticut – Kate McEvoy, JD, Deputy Director
- ARC/Connecticut – Quincy Abbot; Lynn Warner, Executive Director
- Connecticut Association of Not-for-Profit Providers for the Aging (CANPFA) – Mag Morelli, President
- Connecticut Association of Resident Services Coordinators – Stacey Walker; Mary Priestman
- Connecticut Commission on Aging – Julie Evans Starr, Executive Director
- Connecticut Council on Developmental Disabilities – Mary Eberle, Chair, Planning Committee
- Connecticut Disability Advocacy Collective – Stan Kosloski, Project Director; Jayne J. Kleinman, M.S., CRC
- National Multiple Sclerosis Society, Greater Connecticut Chapter – Susan Raimondo, family caregiver representative to the Long-Term Care Advisory Council
- New Haven Legal Assistance Association – Sheldon Toubman
- Sue Pedersen, representing deaf, deaf/blind and hard of hearing consumers
- University of Connecticut Health Center’s Center on Aging -- Julie Robison, Ph.D.; Cindy Gruman, Ph.D.

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<sup>1</sup> Copies of the public comments are available through the Long-Term Care Advisory Council. Contact Co-Chair Julie Evans Starr at the CT Commission on Aging office at 860-240-5200 or at [coa@cga.ct.gov](mailto:coa@cga.ct.gov) .

## **APPENDIX E.**

### **LONG-TERM CARE PLANNING AND PROGRAM IMPLEMENTATION EFFORTS**

#### **A. Long-Term Care Planning Committee Efforts**

##### **Establishment of the Long-Term Care Planning Committee**

The Long-Term Care Planning Committee (Planning Committee), created in 1998 under Public Act 98-239, was established for the purpose of exchanging information on long-term care issues, coordinating policy development and establishing a long-term care plan. The Planning Committee is comprised of representatives from ten State agencies and the Chairs and Ranking Members of the General Assembly's Aging, Human Services, and Public Health Committees. (See Appendix A for the authorizing statute and Appendix B for a listing of Planning Committee members.)

The Planning Committee grew out of the recommendations of a December 1996 report issued by the Legislative Program Review and Investigations Committee. The study concluded that the State's structure for planning, funding and overseeing long-term care services needed reinforcement and coordination. The Legislative Program Review and Investigations Committee recommended the creation of an interagency committee to "exchange information on long-term care issues, ensure coordinated policy development, and establish a long-term care plan."

In addition to the Long-Term Care Planning Committee, Public Act 98-239 also established the Long-Term Care Advisory Council (Advisory Council) to advise and make recommendations to the Planning Committee. The Advisory Council members include a balance of consumers, providers and advocates representing a wide range of interests. (See Appendix C for a listing of Advisory Council members.)

Originally, the Planning Committee was required to establish a long-term care plan for the elderly that integrates the three components of a long-term care system including home and community based services, supportive housing arrangements and nursing facilities. Subsequently, Public Act 01-119 broadened the Planning Committee's purview by requiring a plan for all persons in need of long-term care.

##### **Long-Term Care Planning Committee Products**

###### ***Preliminary Long-Term Care Plan – 1999***

As noted above, the Planning Committee was created by statute in 1998 and held its initial meeting in August 1998. The Planning Committee's authorizing statute required the Planning Committee to produce its first Long-Term Care Plan by January 1999. The Planning Committee members felt that given the short timeframe, it would not be

possible to develop a comprehensive Plan and rather produced a Preliminary Long-Term Care Plan that provided a description of Connecticut's long-term care system in order to develop a baseline for future Plans. In addition, the Preliminary Plan was focused on long-term care for elderly persons in keeping with the original statutory charge for the Planning Committee (this requirement was later changed, through Public Act 01-119, to require the Long-Term Care Plan to address all individuals who need long-term care, regardless of age or disability). The Planning Committee then began the work to develop a comprehensive Long-Term Care Plan due to the General Assembly by January 2001 (the original statute required a Long-Term Care Plan every two years – this requirement was later changed, through Public Act 01-119, to mandate a Plan be developed every three years).

### ***Home Care Report – 2000***

In 1999, the General Assembly enacted Public Act 99-279 that required the Planning Committee to develop, by February 2000, a plan that ensures the availability of home care services for elderly persons under the Connecticut Home Care Program for Elders (CHCP) who would otherwise qualify for the program except their income exceeds the program's established income limits. The impetus for this legislation was the fact that the CHCP had a strict income eligibility requirement that resulted in individuals with as little as one dollar above the income level being ineligible for home care services. This contrasted with the income requirements for nursing home coverage through Medicaid that allows individuals with incomes that are not sufficient to pay for their care to be eligible while contributing most of their income towards their care.

To meet this requirement, the Planning Committee produced a report titled "Home Care for Older Adults - A Plan for Increasing Eligibility Under the Connecticut Home Care Program for Elders." that was delivered to the General Assembly in February 2000. The report concluded that the only mechanism to assure the availability of home care services under the CHCPE was to revise the income eligibility cap to mirror the income requirements utilized for nursing home care eligibility, thus allowing individuals to buy into the CHCPE.

During the 2000 legislative session, the General Assembly approved legislation that revised the income requirements for both the State-funded and Medicaid components of the CHCP to allow individuals with incomes in excess of the income eligibility cap to become eligible for the CHCP by buying into the program. The expanded income level was implemented for the State-funded portion of the CHCP in October 2000. However, to implement a similar revision for the Medicaid portion of the CHCP, federal approval was needed. The Department of Social Services (DSS) submitted a revision to their CHCP Medicaid waiver in 2001, but the DSS proposal was not approved by the federal government.

### ***Long-Term Care Plan - 2001***

After the completion of its Preliminary Long-Term Care Plan in 1999, the next Plan from the Planning Committee was due by January 2001. Beginning in early 1999, the

Planning Committee undertook an ambitious effort to solicit public input regarding what was needed for a comprehensive Long-Term Care Plan.

In March 1999, the Planning Committee, in conjunction with the Advisory Council, held a public hearing at the Legislative Office Building where over 50 individuals provided testimony regarding Connecticut's long-term care system. The Planning Committee then embarked on a series of meetings with a variety of groups and organizations involved with the long-term care system. Most of the groups were members of the Advisory Council. All told, Planning Committee and Advisory Council members held 24 forums throughout 1999 and 2000. In addition, the Planning Committee and Advisory Council held five public hearings throughout the state in 2000 to garner additional feedback and input for the Long-Term Care Plan.

The input gathered through the forums and public hearings helped develop the framework for the Planning Committee's Long-Term Care Plan that was submitted to the General Assembly in January 2001.

#### ***Long-Term Care Plan – 2004***

The Long-Term Care Planning Committee's third plan was issued in January 2004 in accordance with Public Act 01-119 which required the Planning Committee to issue its long-term care plan every three years instead of every two. Working in partnership with the Long-Term Care Advisory Committee, the Planning Committee began work on the Plan in 2003. The Advisory Council worked with the Planning Committee in four essential areas: providing data, identifying areas of need, developing priorities and recommendations, and obtaining public input.

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

#### ***2004 Long-Term Care Plan Status Reports***

Following the release of the 2004 Long-Term Care Plan, a status update was issued annually in June of 2004, 2005 and 2006. The first section of the Status Report described progress implementing the recommendations made in the 2004 Long-Term Care Plan by State Agencies or the legislature, along with any new funds appropriated. The second section documented the implementation of the actions steps issued in Connecticut's Olmstead Plan, entitled "Choices are for Everyone", developed by the Department of Social Services in collaboration with the Long-Term Care Planning Committee and the Community Options Task Force. (See Appendix F)

#### ***Long-Term Care Website***

In 2002, the General Assembly passed Public Act 02-7 (May 9 Special Session) that required the Office of Policy and Management (OPM), within existing budgetary resources and in consultation with the Select Committee on Aging, the Commission on

Aging and the Long-Term Care Advisory Council, to develop a consumer-oriented website that provides comprehensive information on long-term care options that are available in Connecticut.

In September 2006, the Connecticut Long-Term Care Services and Supports website was completed and released to the public ([www.ct.gov/longtermcare](http://www.ct.gov/longtermcare)). The goal was to develop a website that provides easy access to comprehensive information on private and public long-term care services and supports in Connecticut, including home care, community care, housing and institutional/ nursing home care. The website provides information to all individuals in need of long-term care services and supports, regardless of age or disability.

### ***Policy Statement Formalized into Law***

Public Act 05-14 codifies in law a broad philosophical statement to guide future policy and budget decisions. As a result of this legislation, the policy and planning work done through the Long-Term Care Planning Committee is required to “provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting.” This statement positions Connecticut to make the necessary changes to the laws and regulations that govern the State’s long-term care system to make real choices for consumers a reality.

### ***Long-Term Care Needs Assessment***

Currently, a Needs Assessment on long-term care services and supports in Connecticut is being conducted by the University of Connecticut Health Center’s Center on Aging. The General Assembly’s Commission on Aging, in consultation with the Long-Term Care Advisory Council and the Long-Term Care Planning Committee, contracted with the Center on Aging to conduct a comprehensive needs assessment of the unmet long-term care needs in the state and projections of the future demand for these services. This Needs Assessment was mandated by Public Act 06-188, Section 38, and funded with a \$200,000 appropriation from the Connecticut General Fund and an additional \$80,000 from the Connecticut Long-Term Care Ombudsman Program. Preliminary findings from the Needs Assessment are included in this Plan.

## **B. Olmstead Planning Efforts**

On June 22, 1999, the United States Supreme Court decided the *Olmstead v. L.C.* case, holding that unjustified isolation, caused by unjustified placement or retention of persons with disabilities in institutions, should be regarded as discrimination based on disability, in violation of the Americans with Disabilities Act (ADA).

Federal regulation requires public entities to make “reasonable modifications” to their policies, practices, or procedures in order to avoid discrimination on the basis of disability, unless the modifications would “fundamentally alter” the nature of the service or program. As part of the Olmstead decision, four Justices stated that one of the ways the reasonable modification standard could be met is if the State had a comprehensive,

effectively working plan of placing qualified persons with disabilities in less restrictive settings.

In 2000, the Department of Social Services began developing an Olmstead Plan and the Long-Term Care Planning Committee provided oversight and leadership for the process. In order to assure that individuals with disabilities and family members of persons with disabilities were active participants in the development of the Olmstead Plan, a Community Options Task Force was created to take the lead in the development of the Plan. The men and women of this advisory group, made up of adults of all ages with various disabilities, family members of persons with disabilities, and representatives from the elder community, worked hard on Connecticut's Community Options Plan, entitled "Choices are for Everyone," for two years.

On March 25, 2002, the "Choices are for Everyone" Plan was completed as a collaboration between the Department of Social Services, the Long-Term Care Planning Committee and the Community Options Take Force.

A number of activities are ongoing in Connecticut that support the goals outlined in the "Choices are for Everyone" Plan. These activities are described below.

#### **"Choices are for Everyone" Plan -- Action Steps Update**

"Choices are for Everyone" included a series of Action Steps. The Long-Term Care Planning Committee committed to the implementation of these Action Steps over the next several years. Appendix F provides a status report on the Action Steps.

#### **Systems Change Grants**

Since 2002, the goals of this Plan have been furthered through the work accomplished with the funding of seven *Systems Change for Community Living* grants awarded to Connecticut by the Centers for Medicare and Medicaid Services (CMS) as part of the federal New Freedom Initiative. These grants were designed to assist states in their efforts to remove barriers to equality for individuals living with disabilities or long-term illnesses, enabling them to live in the most integrated setting suited to their needs, exercise meaningful choices about their living arrangements and exercise more control over the providers of the services they receive.

The directors of the federal System Change Grants awarded to Connecticut have been meeting together on a regular basis to coordinate their efforts, sharing information, ideas and resources. From 2003 to 2006, they have made an annual joint presentation to the Long-Term Care Planning Committee, relating their work and progress to the goals of the 2004 Long-Term Care Plan. They have also provided valuable information and recommendations for this 2007 Plan.

#### ***Nursing Facility Transition Grant: 2001-2004***

In September 2001, the Department of Social Services received a three-year Nursing Facility Transition grant of \$800,000 to help transition individuals with disabilities out of nursing homes and back to the community. The goal was to develop an effective system of transition for individuals residing in nursing facilities who want to return to

independent community living, transitioning 150 people out of nursing facilities over the course of the grant. The Connecticut Association of Centers for Independent Living was responsible for the overall management and administration of the grant activities, which included: 1) designing and implementing an outreach campaign with materials that inform nursing facility residents and their families about long-term care alternatives and 2) developing and implementing a volunteer peer support network to provide technical assistance to people who are making the transition to the community.

Through the efforts of the Nursing Facility Transition grant, 101 people were transitioned from residing in a nursing home to the community over the course of the three year federal grant period. The project was estimated to save nearly \$2.8 million in Medicaid nursing home expenditures. The average daily saving per person after transition was \$95.90 per day. The availability of affordable and accessible housing was a key need for those transitioning. To address transition related expenses, the program created a “common sense fund” that participants could access when no other funds were available.

To continue the work begun with this grant, \$267,000 in state funds were appropriated for SFY 2006 and a total of \$375,000 are available in SFY 2007 to support the transition of individuals wishing to move from a nursing home to the community.

***Real Choice Systems Change Grant: 2002- 2005***

On October 1, 2002, a three-year \$1.385 million Real Choice Systems Change grant was awarded to the Department of Social Services (DSS) to design and implement effective and enduring improvements in community long-term support systems enabling children and adults with disabilities or long term illnesses to live and participate in their communities. DSS contracted with the University of Connecticut’s Center for Disabilities to implement this initiative. Addressing individuals across the lifespan, the primary goals of the Real Choice grant were twofold: to build the capacity within Connecticut to support informed decision-making, independent living, and a meaningful quality of life for persons with disabilities; and to assist three communities in Connecticut to become models of support for opportunities and choices for persons with disabilities.

In the spring of 2003, three Connecticut towns, Bridgeport, Groton, and New Haven, were awarded model community inclusion grants. Over three years, each community received \$75,000 to support activities to enhance inclusion efforts for persons with disabilities and their families.

***Community-integrated Personal Assistance Services and Supports (C-PASS) Grant: 2003-2006***

On October 1, 2003, a three-year, \$585,000, C-PASS grant was awarded to the Department of Social Services (DSS) to address the development of a personal assistance workforce by building an infrastructure that will allow for the effective recruitment and retention of direct support personnel. As with the Real Choice Grant, DSS contracted with the University of Connecticut’s Center for Disabilities to implement this initiative. The grant has three main objectives: (1) develop a single statewide tool to recruit personal assistants for permanent and backup employment; (2) create a strategic

marketing plan to recruit personal assistants; and (3) provide training for employers of personal assistants.

***Independence Plus Waiver Initiative: 2003-2006***

On October 1, 2003, a three-year \$175,000 Independence Plus Waiver Initiative was awarded to the Department of Mental Retardation (DMR) to help consumers and their families develop and manage individual budgets for their services and supports.

***Quality Assurance and Improvement in Home and Community-Based Services: 2003-2006***

On October 1, 2003, a three-year \$499,000 Quality Assurance and Improvement in Home and Community-Based Services initiative was awarded to DMR to implement its comprehensive quality improvement review system.

***Mental Health Transformation Grant: October 2005 – September 2010***

In October 2005, Connecticut was one of seven states to be awarded a Mental Health Transformation Grant, receiving \$13.5 million over five years. Collaborating on this grant are 14 State agencies and the Judicial Branch, providers and consumers, who are addressing the needs of all individuals with mental health needs across the lifespan. A needs assessment and comprehensive state mental health plan was completed by September 2006 that directs system transformation activities. Grant funds cannot be used for direct services, only for system transformation activities, such as public awareness, information systems, workforce development and quality assurance.

***Medicaid Infrastructure Grant: October 2005 – September 2010***

In October 2005, the Bureau of Rehabilitation Services was awarded a five year, \$15 million Medicaid Infrastructure Grant (MIG). The MIG is not a new grant, but has renewed funding and expanded purpose. The first grant received in 2000 focused on Medicaid for the employed with disabilities. In this new cycle of funding, received on January 1, 2006, the project has taken a broader view, looking toward a comprehensive employment structure for everyone. The vision is to achieve full participation and increase employment, increase earnings and independence and increase access to long-term care services and supports.

***Money Follows the Person Rebalancing Demonstration: January 2007***

In January 2007, Connecticut was awarded a \$24.2 million five year grant from the federal Department of Health and Human Services (DHHS) to participate in the Money Follows the Person Rebalancing Demonstration. Under this program, Medicaid funding is allowed to follow Medicaid eligible individuals living in a nursing home or other institution as they move out to live in the community and receive community-based services. The federal government will reimburse the state for 75 percent of costs for the first year back in the community, instead of the customary 50 percent. The program will serve 700 individuals across the age span with physical disabilities, mental illness and mental retardation. For eligible individuals, Medicaid funding will cover 24-hour live in assistance, personal management, and home alterations, among other home and community-based services.

### **Connecticut Behavioral Health Partnership**

Operation of the Connecticut Behavioral Health Partnership program began on January 1, 2006, serving children and families enrolled in the state HUSKY A and B programs and DCF involved children with special behavioral health needs. DCF and DSS have formed the Behavioral Health Partnership to plan and implement an integrated public behavioral health service system for children and families. The primary goal is to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve member outcomes. Secondary goals include better management of state resources and increased federal financial participation in the funding of behavioral health services.

The Behavioral Health Partnership is designed to eliminate the major gaps and barriers that exist in the current children's behavioral health delivery system. As such, both Departments are committing resources to develop a full continuum of behavioral health services for children that include evidenced based programs, non-traditional support services and community based alternatives to restrictive institutional levels of care. Through collaboration with family members, providers and social support systems, the Behavioral Health Partnership promotes a strengths based treatment approach that focuses on client success. Particular attention is given to the cultural needs and preferences of the child and family and treatment planning reflects this focus on cultural competency.

### **C. Recent Long-Term Care Initiatives**

Since the last Long-Term Care Planning Committee's Long-Term Care Plan, issued in January 2004, progress has been made in Connecticut in the development and expansion of home and community-based services. These services assure that elders and individuals with disabilities have choices that allow them to reside in their communities and avoid institutional care.

### **New and Expanded Home and Community-Based Services (HCBS) Programs**

#### ***Connecticut Home Care Program for Elders (CHCP)***

For the CHCP, funding was increased by \$2.1 million in SFY 2005 in recognition of the continued growth of the program. For SFY 2007, \$900,000 was appropriated to increase the asset limit. As of April 1, 2007, assets for a single person must not exceed 150 percent of the minimum community spouse protected amount, up from 100 percent, and for couples, assets must not exceed 200 percent of the minimum community spouse protected amount, up from 150 percent. In order to continue the State-funded CHCP program, including maintaining the no-waiting list policy and continuing the new Personal Care Assistance Pilot initiative begun in SFY 2005, funding was increased by \$4.6 million in SFY 2006 and \$9.7 million in 2007, for a total appropriation of \$43.8 million in SFY 2006 and \$50.2 million in SFY 2007.

***Personal Care Assistance Medicaid Waiver***

The Personal Care Assistance Medicaid Waiver for persons age 18 to 64 was renewed in September 2004, increasing the amount of hours a Personal Care Assistant (PCA) may work for a single client from 25 ¾ hours a week to 40 hours. Program capacity was expanded by 200 slots, from 498 to 698. If a PCA works more than 25 ¾ hours for one client then the client (the employer) is required to purchase Workers Compensation insurance. In SFY 2007, the program extended eligibility to include individuals age 65 and older.

***State-Funded Personal Care Assistance (PCA) Pilot***

The state-funded PCA Pilot within the CHCP was expanded from 50 to 100 slots in September 2004 by the Department of Social Services. In SFY 2006, the program was repealed and replaced by a less restrictive pilot program that allows recipients' relatives, other than a spouse, to act as a PCA. In addition, the number of people who may participate in the PCA Pilot was increased from 100 to 150 in SFY 2006 and from 150 to 250 in SFY 2007. In SFY 2007, \$2.1 million was appropriated for the program expansion to 250 slots.

***Katie Beckett Medicaid Waiver***

The Katie Beckett Medicaid Waiver was expanded from 125 to 180 slots. The program offers case management and home health services primarily to disabled children who would normally only qualify for Medicaid in an institution. An appropriation of \$1.5 million was made in both SFY 2006 and 2007 to support the expansion.

***Individual and Family Support Medicaid Waiver***

In February 2005, a new Individual and Family Support Medicaid Waiver was awarded to the Departments of Mental Retardation and Social Services by the federal Centers for Medicare and Medicaid Services. The purpose is to strengthen supports to families or individuals and permit the individual who requires long-term support and services to live in the family residence or their own home.

***Pilot Autism Program***

Funds were appropriated in SFY 2007 (\$1 million) to establish a pilot autism spectrum disorders program for individuals who do not have mental retardation. The pilot program, which began in October 2006 and will run through October 2008, will serve a maximum of 50 people and provide a coordinated system of supports and services.

***Program for Adults with Severe and Persistent Psychiatric Disabilities***

In SFY 2007, \$1,725,000 was appropriated to support the development and implementation of a Medicaid Home and Community-based Services (HCBS) Program for Adults with Severe and Persistent Psychiatric Disabilities who are discharged or diverted from nursing home residential care. The Department of Mental Health and Addiction Services and the Department of Social Services are currently drafting a waiver application.

***Program for People with AIDS and People with Multiple Sclerosis***

In SFY 2007, \$400,000 was appropriated for the development of two HCBS Medicaid waiver programs for people with AIDS and people with Multiple Sclerosis.

**Expanding Assisted Living Options**

Over the past several years, the Department of Economic and Community Development (DECD), the Department of Social Services (DSS), the Office of Policy and Management (OPM), and the Connecticut Housing Finance Authority have been developing the Assisted Living Demonstration Project, which, when fully operational, will provide 224 subsidized assisted living units in four communities. The first units became available in Glastonbury in 2004. Since then, the projects in Hartford, Middletown and Seymour have all been completed and are being occupied by clients of the CHCP.

In addition to the Assisted Living Demonstration Project, assisted living options have been extended to State-funded congregate housing, federally financed Housing and Urban Development (HUD) complexes and private pay assisted living facilities, described below.

***Congregate Housing***

Beginning in 2001, DECD and DSS introduced assisted living services within State-funded congregate housing facilities. Fifteen of the 23 congregate facilities are participating in this service expansion. As of November 2006, 168 congregate housing residents were actively enrolled in the assisted living program. From when the program was implemented in May 2001, to November 2006, a total of 512 residents have received assisted living services through the program.

The development by DECD of 95 new congregate units with enhanced core services and the option to provide assisted living services is currently underway. These new units, which are expected to be completed within the next two-three years, will be built in Bridgeport, Waterbury and New Haven.

***HUD Complexes***

In addition to congregate settings, assisted living services are also being offered in four federally financed HUD complexes. As of November 2006, 193 residents in the four HUD facilities were actively receiving assisted living services. From when the program was implemented in May 2001, to November 2006, a total of 376 residents have received assisted living services in federally financed HUD complexes.

***Private Pay Assisted Living Pilot***

In August of 2002 the General Assembly authorized the development of two private pay assisted living pilot programs to help residents in private pay assisted living facilities avoid entrance to a nursing home once they have exhausted their personal resources. There was a 50 person Medicaid pilot and a 25 person State-funded pilot through the CHCP. Subsequent to the program beginning implementation, the General Assembly combined the two pilots so that there is one pilot that can accommodate up to 75 clients of the CHCP, regardless of whether they are Medicaid or State-funded.

The pilot allows persons residing in private pay assisted living facilities to receive support from Medicaid or the State-funded component of the CHCP, for their assisted living services once they have exhausted their resources. While the pilot will not pay for any room and board charges, it will help subsidize the costs for services, which often can be the reason the individual can no longer afford to live in the facility.

The pilots began implementation in January 2003. As of November 2006, 72 individuals were receiving services under the pilots, with an additional 69 individuals having applied for the program.

### **Moratorium on Construction of Nursing Facility Beds**

In 1991, Connecticut established a moratorium on the construction of new nursing facility beds with limited exceptions. In 2001, the General Assembly extended the moratorium to 2007 because nursing facility occupancy rates had not reached capacity and continued to drop over the years. Between September 30, 1995 and 2006, the number of nursing facility beds in Connecticut decreased by 2,397 or 7.5 percent, from 32,054 to 29,657. The occupancy rate on September 30, 1995 was 95 percent and in 2006 was 93 percent.<sup>2</sup>

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<sup>2</sup> Office of Policy and Management, Connecticut Annual Nursing Facility Census

**APPENDIX F.**  
**Status Report:**  
**2004 Long-Term Care Plan for Connecticut**  
**and**  
**“Choices are for Everyone” Plan – Action Steps**  
**June 2006**

# **Status Report**

**JUNE 2006**

**2004 LONG-TERM CARE PLAN FOR CONNECTICUT**

**AND**

**“CHOICES ARE FOR EVERYONE” PLAN – ACTION STEPS**

## Status Report – June 2006

### 2004 LONG-TERM CARE PLAN FOR CONNECTICUT

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
<p>The Governor and General Assembly should consider legislation that will create in statute the following broad philosophical statement to guide future policy and budget decisions: <i>Individuals should receive care in the least restrictive setting with institutional care provided as a last resort.</i></p>		<p>Public Act 05-14 requires Connecticut's long-term care policy and plan, as developed by the Long-Term Care Planning Committee, to <i>provide that individuals with long-term care needs have the option to choose and receive long-term care and support in the least restrictive, appropriate setting.</i></p>
<p>To assist in the implementation and refinement of recommendations and action steps of this Plan, adequate resources must be allocated to accomplish such a comprehensive assessment and analysis.</p>		<p>Public Act 06-188, Section 38, requires the General Assembly, in consultation with the Commission on Aging, the Long-Term Care Advisory Council and the Long-Term Care Planning Committee, to contract for a comprehensive needs assessment of the unmet long-term care needs in the state and projections of the future demand for these services. The assessment must address the long-term care needs of people of all ages and disabilities. SFY 2006-2007: \$300,000</p>
<p><b><i>Balancing the Ratio of Home and Community-Based and Institutional Care</i></b></p>		
<p>Connecticut should work to develop a system that provides for more choice, increasing the percentage of Medicaid long-term care clients receiving home and community-based care from 48 to 75 percent by 2025, requiring approximately a one percent increase in the percentage of Medicaid long-term care clients served in the community every year.</p>	<p>The percentage of CT Medicaid long-term care clients receiving home and community-based care increased by four percent over the course of SFY 2004 and 2005. Due to necessary adjustments to the original client count, the SFY 2003 percent of long-term</p>	<p>Public Act 04-216 increases funding for the Connecticut Home Care Program by \$2.1 million in recognition of the continued growth in enrollment. SFY 2004-2005: \$2,100,000</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	<p>care clients served in the community was recalculated to be 46 percent, rising to 50 percent in SFY 2005.</p> <p>Furthermore, the proportion of Medicaid long-term care expenditures for home and community care increased from 31 percent in SFY 2003 to 35 percent in SFY 2005.</p> <p>The Personal Care Assistance Medicaid Waiver for persons age 18 to 64 was renewed in September 2004 and added 200 individuals, increasing the limit from 498 to 698 participants. The renewed waiver also increases the number of hours per week that a particular personal care assistant can work for a single client from 25 <math>\frac{3}{4}</math> hours to 40 hours. If a personal care assistant works more than 25 <math>\frac{3}{4}</math> hours for one client then the client (the employer) is required to purchase Workers Compensation insurance.</p> <p>A fourth HUD assisted living pilot has been conditionally approved for a HUD community in Talcottville pending approval of their Managed Residential Community designation by the Department of Public Health.</p> <p>On February 1, 2005, the Department of Social Services and the Department of Mental Retardation were awarded an Individual and Family Support Medicaid Waiver by the federal Centers for Medicare and Medicaid Services. The purpose is to strengthen supports to families or individuals and permit the individual who requires long-term support and service to</p>	<p>Public Act 04-216 provides the Department of Social Services with \$2.2 million to expand the Medicaid Personal Care Assistance (PCA) Waiver. Effective July 1, 2004, the number of individuals served under the program increased from 498 to 698. SFY 2004-2005: \$2,200,000</p> <p>Public Act 04-216 appropriates \$50,000 in additional funds to allow for continued enrollment in the Assisted Living Pilot in the 3 federally financed HUD facilities. SFY 2004-2005: \$50,000</p> <p>Public Act 04-258 and Public Act 04-216 combine the 50 person limit on the Medicaid portion and the 25 person limit on the State funded portion of the Private Pay Assisted Living Pilots to allow continued enrollment and reduce the likelihood that residents will be turned away from the program. In addition, \$182,000 is appropriated to support the pilot. SFY 2004-2005: \$182,000</p> <p>Public Act 04-258 transfers \$1 million from the State Department of Education to the Department of Mental Retardation (DMR) and Public Act 04-216 appropriates \$3.6 million to DMR to support residential services for an estimated 150 people currently on the DMR waiting list. This funding also provides enhanced family support to an estimated 100 people. SFY 2004-2005: \$3,600,000</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	<p>live in the family residence or their own home. This waiver has been designated as an <i>Independence Plus</i> Waiver as it anticipates supporting at least 1,000 individuals who self-direct his/her own services.</p> <p>Effective October 1, 2005, the Department of Social Services and the Department of Mental Retardation received approval of a new Comprehensive Supports Medicaid Waiver to replace the DMR Consolidated Medicaid Waiver. The new Comprehensive Medicaid Waiver incorporates self-direction options which further increase choice for Connecticut consumers of long-term care supports.</p> <p>The Connecticut Nursing Facility Transition Project is now funded by the State to continue its work of (1) transitioning individuals from nursing facilities to the community and (2) systems change.</p>	<p>Special Act 04-2 provides the Department of Economic and Community Development with \$2.5 million in bond funds for the development of an additional state-funded congregate housing facility to house up to 50 individuals. SFY 2004-2005: \$2,500,000</p> <p>Public Act 05-251 appropriates funding for services and supports to 150 individuals on the DMR waiting list and enhanced family supports to 100 individuals on the DMR planning list each year of the biennium. Funding also includes rent subsidies for an estimated 75 of the 150 individuals to receive residential services. SFY 2005-2006: \$8,500,000 SFY 2006-2007: \$17,100,000</p> <p>Public Act 05-280, Section 10, increases the asset limits for the State-funded Connecticut Home Care Program for the Elderly (CHCP). As of April 1, 2007, assets for a single person must not exceed 150 percent of the minimum community spouse protected amount, up from 100 percent, and for couples, assets must not exceed 200 percent of the minimum community spouse protected amount, up from 150 percent. SFY 2006-2007: \$900,000</p> <p>Public Act 05-280, Section 56: Currently in statute, licensed community residences housing six or fewer individuals with mental retardation or children with mental or physical disabilities must not be treated differently in zoning regulations than any single family residence. Any licensed</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		<p>community residence that houses six or fewer individuals receiving mental health or addiction services are added to this list.</p> <p>Public Act 05-280, Section 85: On or before July 1, 2005, the Commissioners of the Department of Social Services and Mental Health and Addictions Services must convene a task force to develop a feasibility plan to obtain a federal waiver to establish a Medicaid home and community-based pilot program to provide community-based services and, if necessary, housing to adults with severe and persistent psychiatric disabilities discharged or diverted from nursing home care. The task force is required to report to the Governor and General Assembly by January 1, 2006.</p> <p>Public Act 05-251 appropriates funds for the CHCP, including maintaining the no-waiting list policy and continuing the new 100 person PCA Pilot initiative begun in SFY 2005.  SFY 2006: \$26.5 million  SFY 2007: \$60.9 million</p> <p>Public Act 05-251 appropriates funds to expand slots for the Katie Beckett Waiver from 125 to 180 slots. The program offers case management and home health services primarily to disabled children who would normally only qualify for Medicaid in an institution.  SFY 2005-2006: \$1,500,000  SFY 2006-2007: &amp;1,500,000</p> <p>Public Act 05-251, Section 57,</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		<p>appropriates funds to the Department of Mental Retardation for a pilot program for autism services. SFY 2005-2006: \$250,000</p> <p>Public Act 06-188, Section 37, requires the Department of Mental Retardation, in consultation with the Commissioners of Social Services and Mental Health and Addiction Services, to establish a pilot autism spectrum disorders program for individuals who do not have mental retardation. Serving a maximum of 50 people, the program must provide a coordinated system of supports and services that include service coordination, supported living, supported employment and transportation. The pilot program must start by October 1, 2006 and terminate no later than October 1, 2008. SFY 2006-2007: \$1,000,000</p> <p>Public Act 06-188, Section 8, extends eligibility for the Personal Care Assistance Waiver to older adults, allowing individuals age 18 and older with disabilities to participate.</p> <p>Public Act 06-188, Sections 32 and 52, allow the Department of Social Services, in consultation with the Department of Mental Health and Addiction Services (DMHAS) and the Mental Health Strategy Board, to seek either a State Plan Amendment or Medicaid waiver to implement a Medicaid-financed home and community-based program for adults with severe and persistent psychiatric disabilities who are discharged or diverted</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		<p>from nursing home residential care. Funds are appropriated to DMHAS for establishing and implementing this program. SFY 2007 \$1,725, 000</p> <p>Public Act 06-186 appropriates funds for the development of two Medicaid home and community-based waiver programs for people with AIDS and people with Multiple Sclerosis. SFY 2006-2007: \$400,000</p> <p>See other initiatives under specific topics in this report.</p>
<b><i>Balancing the Ratio of Public and Private Resources</i></b>		
<p>Connecticut should strive over the next 20 years to increase the proportion of long-term care costs covered by private insurance and other dedicated sources of private funds to 25 percent.</p>	<p>Over 40,000 individuals have purchased Connecticut Partnership-approved long-term care insurance policies. The Connecticut Partnership has saved Medicaid an estimated \$2.8 million to date.</p>	
<b><i>Home and Community-Based Infrastructure</i></b>		
<p>Examine the possibility of providing greater uniformity among the different Medicaid home and community-based waivers in terms of requirements such as age and income limits, and of providing maximum flexibility and choice as to how waiver funds can be utilized.</p>	<p>DSS is investigating with the Centers on Medicare and Medicaid whether individuals aging out of the Acquired Brain Injury (ABI) and the Personal Care Assistance (PCA) Waivers could be grandfathered into these programs beyond the 65 year age limit with appropriate administrative and legislative approvals.</p>	<p>Public Act 06-188, Section 8, extends eligibility for the Personal Care Assistance Waiver to older adults, allowing individuals age 18 and older with disabilities to participate.</p>
<p>Maximize the involvement of individuals with disabilities and</p>	<p>Representatives of State agencies and</p>	<p>Public Act 06-56 allows the Director of the</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
<p>family members of individuals with disabilities in the development and implementation of Connecticut's long-term care system.</p>	<p>individuals with disabilities attended a meeting:</p> <ul style="list-style-type: none"> <li>▪ In March 2004 in order to share perspectives regarding development of a proposal for a Cash and Counseling Demonstration program in Connecticut.</li> <li>▪ In June 2005 to provide input into the development of a federal Systems Transformation grant and an Aging and Disabilities Resource Center grant.</li> </ul> <p>Each Department of Mental Retardation (DMR) region has an advisory council which includes family members.</p> <p>The following Connecticut System Change Grants from the Centers on Medicare and Medicaid Services have grant Steering Committees with majorities of consumers and families planning and directing project activities – Nursing Facility Transition Project*, Real Choice, C-PASS (Community-integrated Personal Assistance Support Services), Medicaid Infrastructure Grant, Department of Mental Retardation Quality Assurance and Improvement Grant, and Independence Plus Systems Change Grant.</p> <p>* The Nursing Facility Transition Project has ended, however, its work continues with State funding as the Nursing Facility Transition Project (also know as “My Community Choices).</p>	<p>Office of Protection and Advocacy for Persons with Disabilities to establish an accessibility advisory board. The board must be comprised of design professional, people with disabilities, and people whose family members have disabilities.</p>
<b><i>Informal and Formal Caregivers</i></b>		
In order for individuals with disabilities to remain at home or in the	In May of 2004, the University of	Public Act 05-251 appropriates funds for

<b>RECOMMENDATIONS</b>	<b>ADMINISTRATIVE and OTHER ACTIONS</b>	<b>LEGISLATIVE ACTIONS AND NEW FUNDING</b>
<p>community as long as possible, support for family caregivers should take a variety of coordinated forms. These could include information and training, respite services to caregivers, tax benefits and incentives, payment to informal caregivers, transportation alternatives, physical, occupational and speech therapy alternatives, and disability supports.</p>	<p>Connecticut Center on Disabilities and the Department of Public Health co-sponsored a one-day conference for caregivers on care giving for persons with disabilities and special health care needs.</p> <p>In February 2005, the Department of Mental Retardation implemented an Individual and Family Support Medicaid Waiver that provides support to family caregivers.</p>	<p>family respite through the Children's Trust Fund.  SFY 2005-2006: \$500,000  SFY 2006-2007: \$500,000</p>
<p>In addition to continuing existing respite care efforts, Connecticut should expand or replicate its successful Alzheimer's Respite Care program to provide respite services for any caregiver of individuals with disabilities of all ages.</p>	<p>The Department of Social Services received almost \$500,000 in funding for FY 2005 and FY 2006 from the Attorney General from the Mylan Laboratory settlement to provide direct services to people with Alzheimer's and their caregivers.  SFY 2004-2005: \$500,000  SFY 2005-2006: \$500,000</p>	<p>Public Act 06-186 appropriates funds to support the New England Cognitive Center and the Brain Gymm for Alzheimer's patients.  SFY 2006-2007: \$50,000</p>
<p>The State should build on and expand current efforts supported under the National Family Caregiver Support Program, enhancing the basic information, training and respite services that are already provided.</p>		
<p>Connecticut should explore the potential for supporting overnight respite care in settings other than institutions. This should include consideration of licensing and Medicaid reimbursement issues.</p>	<p>Connecticut's National Family Caregiver Support Program subsidizes overnight respite at camps for children being raised by grandparents or relative caregivers.</p> <p>In February 2005, the Department of Mental Retardation implemented an Individual and Family Support Medicaid Waiver that includes an option to enroll overnight respite providers in non-institutional settings.</p> <p>In SFY 2005-2006, the Department of Mental Retardation opened an additional respite home operated by the Department to</p>	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	<p>provide overnight respite for families in the community bring the total across the state to 10.</p> <p>In SFY 2006-2007, the Department of Mental Retardation plans to open two additional respite homes.</p>	
<p>Respite training should be considered as part of the curriculum within appropriate programs at state colleges and universities and other educational settings. Such curriculum also should include a component on self-determination to assist family members in promoting self-determination for their loved ones.</p>		
<p>Training should be developed for public and private providers to better assist families and other informal caregivers to develop the supports necessary to allow a person with disabilities to live in their community.</p>	<p>Connecticut's National Family Caregiver Support Program trains caregivers on how to talk to physicians about their needs.</p> <p>In SFY 2005-2006, the Department of Mental Retardation held an information session for private providers on how to be an "Agency with Choice" to support individuals and their families in hiring and managing support staff.</p>	
<p>Connecticut should continue its efforts on the federal level to enact a tax credit for those providing informal care.</p>		
<p>Connecticut should expand the use of the non-traditional workforce, such as personal care assistants (PCAs), to help address the increased number of individuals desiring home and community-based care. To make the positions competitive and a viable career, these types of jobs will need to provide the necessary worker supports and benefits.</p>	<p>Efforts are underway through the federal Community-integrated Personal Assistant Support Services (C-PASS) grant and the Medicaid Infrastructure Grant (MIG) to increase the availability of a paraprofessional workforce to support people with disabilities. This effort includes a strategic marketing plan to recruit personal assistants for permanent and back up employment in collaboration with the Department of Labor, Community Colleges,</p>	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	<p>Vocational-Technical Schools and other entities. Also, a training manual for implementation through on-site/ in home training is being developed for people with disabilities who hire their own direct support staff. A Website registry created for Personal Care Assistants and employers in Connecticut has been created and implemented (<a href="http://www.rewardingwork.org">www.rewardingwork.org</a> )</p> <p>Where appropriate, individuals in transition from nursing facilities to community under the Nursing Facility Transition Project are referred for the above C-PASS training.</p> <p>In February 2005, the Department of Mental Retardation implemented an Individual and Family Support Medicaid Waiver that allows for the use of a non-traditional workforce providing supports in the community.</p> <p>In October 2005, the Department of Mental Retardation implemented a Comprehensive Supports Medicaid Waiver that allows for the use of a non-traditional workforce providing supports in the community.</p> <p>In SFY 2005-2006, the Department of Mental Retardation developed a Guide to Self-Direction for individuals served by the Department to explain systemic supports available for individuals who choose to hire staff directly.</p> <p>In SFY 2005-2006, the Department of Mental Retardation developed and published training materials for non-traditional workforce providers to improve workforce skills.</p>	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
<p>Connecticut should evaluate the Personal Care Assistance (PCA) Pilot under the Connecticut Home Care Program for Elders (CHCP) to determine the potential for making personal care assistance a permanent benefit. In addition, explore payment for family members for providing personal care.</p>		<p>Public Act 04-258 requires the Department of Social Services, within available appropriations, to establish and operate a state-funded PCA Pilot within CHCP until June 30, 2006. Up to 100 eligible seniors will receive personal care assistance (PCA) as an alternative to regular home health services in order to avoid institutionalization. To qualify for the pilot, seniors must be age 65 or over and meet the eligibility requirements of the CHCP. Recipients' relatives, other than spouses, may act as PCAs in this pilot. The Department of Social Services (DSS) is required to apply for a federal Medicaid waiver to include this PCA pilot in the Medicaid-funded portion of CHCP.</p> <p>Public Act 05-209 amends Public Act 04-258 by increasing the number of people who may participate in the State-funded PCA pilot program from 100 to 150. It also repeals the more restrictive 50-person pilot PCA program established in 2000 for people either (1) transitioning off the state's Medicaid-funded PCA program for younger adults with disabilities or (2) eligible for CHCP but unable to access adequate home care services and grandfathers them into the 150 person PCA Pilot. The requirement that DSS apply for a federal Medicaid waiver to include this PCA pilot in the Medicaid-funded portion of CHCP is repealed.</p> <p>Public Act 06-188, Sec. 9, amends the State-funded PCA pilot program by increasing the number of people who may</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		participate from 150 to 250. SFY 2006-2007: \$2,100,000
<p>Connecticut should develop programs to address the professional workforce shortage. Strategies could include attracting students into the field with scholarships and grants, developing career paths allowing for increases in responsibility, status and wages, enhancing public perception of these jobs, and professionalization of paraprofessional positions. There is also potential for re-training individuals who lose their job in such sectors as manufacturing for a new career in long-term care.</p>	<p>The Connecticut Career Ladder Initiative's Health Care Subcommittee is working to create models for career ladders for nurses and home health aides. Pilot career ladder programs are expected to begin in SFY 2004-2005. Funding options are being explored.</p> <p>In February 2005, the Department of Mental Health and Addiction Services (DMHAS) issued an RFP to nurse aid training organizations capable of training 140 mental health workers in Nursing Assistant Skills and Techniques necessary for the delivery of safe, effective and quality services to individuals served on acute and sub-acute psychiatric units at its Southwest Connecticut Mental Health System site.</p> <p>DMHAS has established a Workforce Development Group with responsibility to address and meet workforce needs and challenges.</p> <p>The 1199 Education and Training Labor/ Management Committee has modified its career mobility eligibility criteria to include incentives for 1199 staff participating in nursing degree programs.</p> <p>Opportunity exists in the Title V Older Workers program to encourage participants in this program with interest in this area to be 'retrained' as a Personal Care Assistant. Work on this has begun with the participating agencies.</p>	<p>Public Act 04-253 establishes a Connecticut Nursing Incentive Program, which the Department of Higher Education (DHE) must administer. An appropriation of \$200,000 is made to DHE in FY 2005 to provide program assistance to the state's four regional community-technical colleges and DHE is allowed to use up to 2% of the funds for program administration in FY 2005 and 2006. The commissioner must (1) adopt regulations establishing program operating guidelines within 90 days after the bill takes effect and (2) by January 1, 2007, submit a status report on the program's establishment and operation to the Education, Public Health, and Higher Education and Employment Advancement committees.</p> <p>SFY 2004-2005: \$200,000</p> <p>Also, the Office of Workforce Competitiveness (OWC) is required to establish a challenge grant program for regional workforce development boards for FY 2005, with \$200,000 appropriated to the office in FY 2005 for the purpose of (1) expanding educational programs directed at providing low wage, low skilled workers with skill assessment and life management support, and (2) training in high growth, workforce shortage areas such as health care and information technology.</p> <p>SFY 2004-2005: \$200,000</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		<p>Public Act 04-220 establishes a 16-member Connecticut Allied Health Workforce Policy Board to work with the Connecticut Career Ladder Advisory Committee. The board must report its findings and recommendations, including recommendations for legislation to address allied health workforce shortages in Connecticut, to the Public Health and Higher Education and Employment Advancement committees by January 1, 2006 and annually afterwards.</p> <p>Public Act 04-2 transfers \$150,000 from DHE to the Office of Workforce Competitiveness for the Connecticut Employment Training Commission. Funds are intended to be used for regional job-training academies with a specific emphasis on nursing and health professions.</p> <p>SFY 2004-2005: \$150,000</p>
<p>Connecticut should increase the capacity of educational institutions to provide training for professional long-term care workers in order to address the current need for and projected growth of these workers in the state.</p>	<p>The U.S. Department of Labor awarded the 12 Connecticut Community Colleges a \$2,147,325 grant to better prepare students who are entering the allied health fields in October 2005. This three year initiative will provide for academic advisors, tutors, online courses, and a new allied health certificate program. It will help train high school and Workforce Investment Board career counselors about nursing and allied health careers. The funds are expected to have a positive impact on 6,000 nursing and allied health students.</p>	<p>Public Act 04-196 establishes a Connecticut nursing faculty incentive program, within available appropriations, to be administered by the Office of Workforce Competitiveness (OWC). The program must provide grants, within available funds, to higher education institutions that work with hospitals to: (1) establish or expand nursing education programs that qualify people to teach or train nursing students enrolled in a bachelors or registered nurse certification program or (2) encourage those who already have those qualifications to serve as full- or part-time faculty members at these institutions. The OWC must submit</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		<p>a status report on the incentive program to the Education, Public Health, and Higher Education and Employment Advancement committees by January 1, 2006. The bill also requires the higher education commissioner to report to the Public Health and Higher Education and Employment Advancement committees by January 1, 2005 on her department's assessment of the current and future capacity of the state higher education system to educate and train nurses.</p> <p>Public Act 04-216 appropriates \$250,000 to establish a nursing faculty incentive program in the State Department of Education in order to provide financial assistance to institutions that secure private funding to increase nursing faculty at the state's community colleges. SFY 2004-2005: \$250,000</p>
<p>Home care agencies, nursing homes, and other long-term care providers need to consider ways to increase the numbers of direct care workers and provide incentives for recruiting and retaining workers.</p>		
<p><b><i>Nursing Facility Transitions</i></b></p>		
<p>Connecticut should continue the efforts begun under the State's Nursing Facility Transition Project (NFTP). Connecticut should build on the successful components of the NFTP and strive to sustain those elements into the future.</p>	<p>As of June 1, 2006, the NFTP has successfully transitioned 119 individuals. Cost benefit analysis calculated on the community supports compared to nursing facility care for 115 individuals transitioned reflects an annualized State Medicaid saving of over \$3.7 million.</p>	<p>Public Act 04-216 continues the efforts of the federally funded NFTP which will expire in September 2004, by providing \$267,000 in state funds for FY 2005. SFY 2004-2005: \$267,000</p> <p>Public Act 06-186 provides funds to continue the NFTP. SFY 2006-2007: \$108,000</p>

<b>RECOMMENDATIONS</b>	<b>ADMINISTRATIVE and OTHER ACTIONS</b>	<b>LEGISLATIVE ACTIONS AND NEW FUNDING</b>
<p>Connecticut should continue its landmark decision to allocate a number of Section 8 vouchers for individuals transitioning from nursing facilities, developed as part of the Nursing Facility Transition Project (NFTP).</p>	<p>Agreement to allocate Section 8 vouchers was sustained for an additional year beginning July 1, 2004. As of June 1st 2005, 25 of the vouchers have "leased-up". In April of 2005, the Department of Social Services (DSS) Housing Unit had to close the Mainstream Section 8 Program. This included vouchers under the Nursing Facility Section 8 Preference. During the period July 1, 2005 through June 1, 2006, the Section 8 program remains closed. The State has continued its support of the NFTP by continuing to allow access to the Rental Assistance Program (RAP) during this year. Then individuals are currently seeking housing with RAP certificates.</p> <p>Additionally, the bonding funds approved for the NFTP for accessibility are providing a needed resource for home modifications for individuals transitioning out of nursing facilities. Access to this program began in April 2005. To date, 10 individuals have explored the program. Two projects have been complete and another two are nearly complete. One problem encountered has been payment of rent on units while they are modified. The Department of Social Services Housing Unit has worked with the NFTP and is adding language to the State Plan to allow Section 8 and Rental Assistance Program to be utilized to pay the rent on a unit for up to two months while it is being modified. This will go into effect on July 1, 2006.</p>	
<p>Connecticut should work with other housing providers, such as</p>		

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Residential Care Homes, Congregate Housing, and others to maximize the housing and service and supports opportunities for individuals transitioning from nursing facilities.		
<b><i>Prescreening Efforts</i></b>		
<p>Connecticut should expand its present commitment to prescreening all applicants to nursing facilities age 65 and older, regardless of their payer status, to include all nursing facility applicants, regardless of their age or payer source. Similar prescreening for all institutions should be developed for individuals with disabilities. Any expansion of prescreening activities should be performed by State agencies. Prescreening should not prohibit or deny applicants the choice to enter an institution. The overall goal of prescreening should be to assure that individuals have the knowledge and opportunity to exercise their choice to live in a community or institutional setting. Prescreening activities need to take into account the specific needs of the individual, addressing both cognitive and physical impairments, and ensure that the person receives the appropriate level of care that will protect them and others from any potential harm. Individuals who chose community settings must have safe and adequate living options and sufficient care giving supports.</p>		
<p>As part of the prescreening efforts, the State, in conjunction with providers and other entities working in the community with individuals with disabilities, should enhance their existing educational efforts with hospitals, physicians, nursing facilities, and other institutions regarding available community options.</p>		
<b><i>Reduction in Beds in Institutions</i></b>		
<p>As nursing facilities and other institutions close, or occupancy levels are reduced, Connecticut should continue to conduct a needs analysis to: 1) determine if any of the beds are needed elsewhere in the system; and 2) de-license the remaining beds.</p>	<p>As the census reduces at the Southbury Training School (STS), the Department of Mental Retardation continues to consolidate and redirect resources to community-based</p>	

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<p>As this occurs, there is an opportunity to redirect the appropriate level of resources to enhance home and community-based services and supports.</p>	<p>programs. In SFY 2004-2005, two residential units were closed due to decreasing population.</p> <p>As a result of further census reductions at STS, positions will be transferred during SFY 2006-2007 and SFY 2007-2008 to expand family support services. The first phase will create staff teams who can provide direct in home family support. The second phase will create the positions needed to open two additional respite centers.</p>	
<p>Connecticut should create incentives for under utilized institutions to convert their facilities to adult day care services, assisted living, residential care homes, independent living communities, or other community housing options. Such incentives could include low-cost financing for conversions and tax credits. Development of any new community housing options should emphasize consumer direction and choice.</p>		
<p>Connecticut should assess the need for extending the moratorium on construction of new nursing home beds when the enabling legislation sunsets in 2007.</p>		
<p><b><i>Federal Reform</i></b></p>		
<p>Connecticut should continue to advocate for changes to federal Medicaid law that will facilitate an expansion of home and community-based options. Connecticut has submitted a proposal to the federal Centers for Medicare and Medicaid Services (CMS) to expand the medically needy income formula allowing individuals with incomes in excess of 300 percent of Supplemental Security Income to be eligible under the Medicaid portion of the Connecticut Home Care Program for Elders (CHCP). This will allow individuals the same access to home and</p>		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
community-based care as they have for nursing facility care.		
In addition, current Medicaid law prohibits the reimbursement of room and board charges for those living in the community. Connecticut should continue its efforts to remove this prohibition or expand other federal programs such as Section 8, allowing more aggressive development of community living options.		
Work with Congress and the Centers for Medicare and Medicaid Services to eliminate the “homebound” definition for Medicare home health care or, at a minimum, liberalize this requirement with respect to individuals with long-term disabilities.		
<b><i>Planning Ahead for Long-Term Care</i></b>		
Connecticut should create new options to encourage personal responsibility and planning and identify and maximize existing non-governmental resources.		As a result of passage of the federal Deficit Reduction Act of 2005 in February 2006, changes are made in the Medicaid rules that will make purchase of long-term care insurance more attractive than estate planning to qualify for Medicaid. The “look back” period for transfer of assets was extended from three years to five years. In addition, changes were made in the start date of the ineligibility period for all transfers made for less than fair market value. Instead of the penalty period beginning when the transfer was made, it begins when the person applies for or begins receiving Medicaid long-term care services.
Connecticut, working with the federal government, should develop incentives for individuals to save for their future long-term care needs. Connecticut should also explore opportunities on the state level to provide tax relief for unreimbursed medical and long-term care expenses.		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
<p>Connecticut should continue, and enhance, the efforts of the Connecticut Partnership for Long-Term Care (Partnership), the State's public/private alliance to help educate Connecticut residents about the importance of planning ahead for future long-term care needs through the purchase of high quality private long-term care insurance (LTCI).</p>	<p>Efforts of the Connecticut Partnership are ongoing. Over 40,000 Partnership policies have been purchased to date. The Connecticut Partnership has provided long-term care planning information to over 85,000 Connecticut residents and has saved Medicaid an estimated \$2.8 million to date.</p>	
<p>The State should take advantage of any opportunities to enhance the educational capabilities of the Partnership through the use of public and private resources.</p>		
<p>Connecticut should explore the development of various products, including a high-risk pool for long-term care insurance to enable individuals who are currently uninsurable to obtain the coverage they need.</p>		
<p>Connecticut should continue its efforts on the federal level to enact an "above the line" tax deduction for the purchase of long-term care insurance. Such a tax deduction would also result in a State tax deduction as long as Connecticut's tax system is tied to the federal Adjusted Gross Income. If federal action on this issue is not taken, Connecticut should explore its own tax incentives for long-term care insurance.</p>		
<p>Connecticut should explore and develop other models for private long-term care insurance.</p>		
<p>Connecticut should examine the state and federal reverse annuity mortgage (RAM) programs to see if any enhancements can be made to increase the usage of this program. Connecticut should also monitor the recently announced initiative from the Centers for Medicare and Medicaid Services to increase the usage of RAMs.</p>	<p>The Reverse Annuity Mortgage program in Connecticut re-opened in November 2003. Applications are accepted at the Department of Social Services Aging Services Division and the Connecticut Housing Finance Authority (CHFA).</p>	<p>The federal Deficit Reduction Act of 2005 also set a limit on the amount of home equity an individual can have and be eligible for Medicaid. The limit is \$500,000, though states have the option to increase the limit to as high as \$750,000. The legislation allows the use of a reverse annuity mortgage as a</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		means of reducing the applicant's home equity below the limit.
<b><i>Community Options</i></b>		
Enhance the capacity of communities to accommodate the needs of individuals with disabilities. Encourage communities to take an active role in long-term care planning for their residents.	Under the federal Real Choice grant, a statewide survey of community inclusion was conducted 2004 to determine the level and quality of inclusion in Connecticut communities. A report on this survey entitled <i>Connecticut Real Choice Consumer Survey: Are Connecticut Citizens With Disabilities Able To Participate In All Desired Aspects Of Community Life In The Town In Which They Live?</i> is available through the A.J. Papanikou Center for Developmental Disabilities (see <a href="#">Connecticut Real Choice Consumer Survey</a> ).	
Expand efforts to promote community inclusion of individuals with disabilities. Build upon the work currently being done with support from Connecticut's Real Choice Grant in three Model Communities -- Bridgeport, Groton and New Haven.	On September 16, 2005 the Real Choice Grant held a conference entitled <i>Creating Inclusive Communities For Everyone</i> . This conference was the culmination of a series of forums on community inclusion held around the state during 2004 and 2005. Attended by over 140 consumers, town officials and advocates, the day was an opportunity for participants to engage in dialogue and discussion around one central question: "How can I help build a welcoming, accessible, and inclusive community that supports all its residents to be full participants?"	
Encourage the adoption of actions developed within Model Communities and the Interburst conferences to reduce the isolation felt by individuals with disabilities living in the community	The town of Groton has incorporated fully inclusive practices into its Department of Recreation lifespan activities and with the	

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and their families.	assistance from the Real Choice Grant is developing a track on inclusion for the 2005 Connecticut Recreation and Parks State Conference. A pilot mentoring project is also being tested in Groton for statewide replication. The City of Bridgeport has conducted training for landlords and developers on Accessible Housing and Universal Design, and plans to incorporate the needs of the disability population into the Consolidated Plan and Bridgeport Housing Authority's five year plan.	
Explore opportunities to strengthen consumer directed care. Examples of promising programs currently being piloted across the country are Money Follows the Person, Cash and Counseling, and Person Centered Planning.	<p>In March 2004, the Department of Social Services (DSS) applied to the Robert Wood Johnson Foundation for a three-year Cash and Counseling Demonstration grant. The funding would support efforts to design an 1115 Medicaid waiver to implement a Cash and Counseling program in Connecticut. The program intended to be cross-disability, age-inclusive and consumer directed and controlled. Although Connecticut was a semi-finalist, the process was highly competitive and Connecticut was not granted the award.</p> <p>Under the federal Real Choice grant, a state agency training needs assessment was completed, published and distributed by August 2004. This report, titled "Beyond Services to Clients: Are We Training Staff to Support Self-Determination and Consumer Decision Making" is a review of staff development principles and practices among state agencies serving persons with disabilities in Connecticut. A follow-up to this report is being planned through a series of focus groups with consumers to be held</p>	Public Act 06-188, Section 44, allows the Department of Social Services to submit an application to the federal Department of Health and Human Services to establish a Money Follows the Person demonstration project. This program has become available through the federal Deficit Reduction Act of 2005. If selected, the Connecticut demonstration program must not serve more than 100 individuals and personal care assistance services must be included in the benefits. The Commissioner may also modify any existing Medicaid home and community-based waiver if necessary to implement the demonstration program.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	<p>in the fall of 2005.</p> <p>The State of Connecticut was awarded a federal Mental Health Transformation State Incentive Grant on October 1, 2005. The Department of Mental Health and Addiction Services (DMHAS) is the lead agency working with 14 other State agencies and the Judicial Branch to build upon and further develop a recovery-oriented system of care in the state. DMHAS envisions a recovery-oriented system of mental health care that will offer Connecticut citizens, across the lifespan, an array of accessible services and recovery supports from which they will be able to choose to address their particular mental health condition or combination of conditions. These services and supports will be culturally and gender-responsive, build on personal, family, and community strengths, and have as their primary and explicit aim, promotion of the person/family's resilience, recovery, and inclusion in community life.</p> <p>The Department of Mental Retardation (DMR) Individual and Family Support Waiver provides increased choices for self direction.</p> <p>DMR and DSS obtained approval to include self-direction in the Department of Mental Retardation Comprehensive Supports Medicaid Waiver.</p>	
<p>Explore the benefits and potential for adding a service to the Connecticut Home Care Program for Elders that allows payment to Adult Day Care Centers for therapies, making them approved rehabilitation sites. This should include consideration of licensing</p>		

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
and Medicaid reimbursement issues.		
<b><i>Housing</i></b>		
Over the next biennium, support the efforts of the Accessible Housing Registry to identify accessible units and increase their utilization.		Public Act 05-239 requires the Department of Economic and Community Development to develop and maintain a comprehensive inventory of all assisted housing in Connecticut by July 1, 2006,
Expand and preserve the stock of housing for elders and persons with disabilities.	<p>The Interagency Council on Supportive Housing and Homelessness is charged with the development of a plan that will create 900-1000 additional units of supportive housing over the next 10 years. A request has been submitted to HUD for \$6.12 million in operating costs and \$14 million in capital costs to support these 900-1000 units of housing. There are currently 380 units of supportive housing in the CHFA pipeline supported by the State's general obligation bonds (\$20 million), CHFA funding (\$9 million) and funds from Department of Economic and Community Development (\$3 million HOME) and Department of Mental Health and Addiction Services (\$3 million).</p> <p>The Interagency Council on Supportive Housing and Homelessness issued its first report in January 2005. Through the Next Step Supportive Housing Initiative, the Council set out an approach to create 1,000 units of affordable, service-supported rental housing over the next three years: 350 apartments for families and 650 for single adults, including 50 for young adults.</p> <p>The 2005-2010 HUD Consolidated Plan set</p>	<p>Public Act 04-1 and Special Act 04-2 establish a pilot program to provide affordable housing and support services to families with children who have serious, chronic medically complex conditions. Up to \$3 million in bond funds is provided to the Department of Economic and Community Development for construction of the housing units. SFY 2004-2005: \$3,000,000</p> <p>Special Act 04-2 provides \$500,000 in financial assistance to non-profit corporations to provide housing and related facilities for persons with AIDS. SFY 2004-2005: \$500,000</p> <p>Public Act 05-9 makes permanent the Department of Mental Health and Addiction Services' community-based, group home pilot program for people with acquired brain injury that was scheduled to end on October 1, 2005. Three homes currently house six people.</p> <p>Public Act 05-280, Section 32, amends the Supportive Housing Initiative by adding a second phase. In the first phase,</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	<p>the following goals:</p> <ul style="list-style-type: none"> <li>* Development of 350-500 units of supportive housing over the next 5 years.</li> <li>* Development of 35 units of congregate housing per year for the next five years.</li> <li>* Development of 170-255 units of housing for persons with AIDS over the next 5 years.</li> <li>* Funding of accessibility modifications for 25-50 housing units per year for 5 years.</li> </ul>	<p>the Supportive Housing Pilots Initiative is required to provide up to 650 additional units of affordable housing and support services. The second phase, the Next Steps Initiative, is required to provide up to 500 additional units of affordable housing and support services. The Connecticut Housing and Finance Authority must issue one or more requests for proposal no later than January 1, 2006. This initiative utilizes the bonding authority of the Connecticut Housing Finance Authority, community mental health services from the Department of Mental Health and Addiction Services and the Department of Children and Families, and Rental Assistance Program certificates from the Department of Social Services.</p> <p>DMHAS  SFY 2005-2006: \$375,000  SFY 2006-2007: \$1,562,500</p> <p>DCF  SFY 2005-2006: \$140,000  SFY 2006-2007: \$175,000</p> <p>DSS  SFY 2005-2006: \$344,250  SFY 2006-2007: \$1,579,250</p> <p>Public Act 06-186 appropriates funds to the Department of Social Services to provide rental assistance to recovering families.  SFY 2006-2007: 1,260,000</p>

<b>RECOMMENDATIONS</b>	<b>ADMINISTRATIVE and OTHER ACTIONS</b>	<b>LEGISLATIVE ACTIONS AND NEW FUNDING</b>
<p>Enforce current standards in Connecticut regulation and statute, including the Building Code, which require builders of new developments to create a certain percentage of wheelchair accessible units.</p>		<p>Public Act 04-237 brings certain structures and parking spaces into more complete compliance with the accessibility requirements of the 1990 federal Americans with Disabilities Act (ADA) and the 1988 Fair Housing Amendments Act (FHAA). Beginning October 1, 2004, accessibility requirements are modified for parking spaces designated for use by the handicapped and accessibility features are required for residential facilities to conform to the standards in the building code rather than statutory specifications. It applies to (1) parking areas, garages, and terminals constructed under a building permit application filed on and after October 1, 2004; (2) state-assisted rental housing or rental housing projects with four or more dwelling units constructed or substantially rehabilitated under a building permit application filed on or after October 1, 2004; and (3) other residential dwellings constructed, substantially renovated, or established by change of use under a building permit application filed on or after October 1, 2004.</p>
<p>Increase outreach to landlords about resources and financing to make their units accessible.</p>		
<p>Increase the utilization of Section 8 Vouchers in communities throughout Connecticut so additional vouchers may be requested from HUD.</p>	<p>Connecticut is now considered a 'high performer' by HUD and is eligible for additional Section 8 vouchers.</p>	
<p>Establish a Resident Services Coordinator in every State-funded Elderly Housing facility. Currently, there is one Resident Services Coordinator in every three facilities.</p>		<p>Public Act 05-206 expands and redefines the responsibilities of resident service coordinators in state-assisted elderly</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
		housing projects by adding: facilitating conflict resolution between residents; establish and maintain relationships with community services providers and link resident to community services; act as a liaison to assist in problem solving; provide orientation services to new residents; and organize resident activities that promote socialization.
Expand assisted living options beyond those available to the elderly.	The Department of Mental Retardation (DMR) included Assisted Living as a Medicaid Waiver funded option under the Comprehensive Supports Waiver effective October 2005. This service is now available to individuals supported by DMR.	
Ensure that all State agencies that construct or rehabilitate housing or provide rental assistance report the accessible units to the accessible housing registry.		
Maintain current building codes for type A units and require local building officials to report such units to the Department of Economic and Community Development as part of the building permit process.		
<b><i>Employment</i></b>		
Explore the development of ongoing tax credits or other incentives for employers to provide support services or assistive technology so that individuals with significant disabilities can both obtain and maintain higher levels of employment for longer periods of time. The current tax credits for employers are short-term or one time credits.	Through the Medicaid Infrastructure Grant, the State embarked on a comprehensive, statewide strategic planning process in the Spring of 2006. A needs assessment is currently underway to identify the key challenges and opportunities facing Connecticut employers, and linking those employers to an untapped workforce of individuals with disabilities and individuals	Public Act 05-44 permits the Department of Social Services to amend the Acquired Brain Injury (ABI) Medicaid Waiver and the Department of Mental Retardation Home and Community-based Services Medicaid Waiver to enable people enrolled in the Medicaid for Employed Disabled (MED) Coverage Group to participate in those waiver programs.

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
	<p>who are aging out of the current economy.</p> <p>The State of Connecticut has recently attracted a major distribution center for Walgreen's. This cross-agency effort will bring jobs to Connecticut, with a target of 1/3 of the distribution center's workforce being individuals with disabilities.</p>	<p>Public Act 06-188, Section 27 expands Medicaid coverage for working persons with disabilities to include individuals who are 65 years of age or older.</p> <p>Public Act 06-129 requires the commissioner of the Department of Administrative Services (DAS) to establish a four-year pilot program to create and expand janitorial jobs for people with disabilities (except for blindness) or a disadvantage (defined as individuals with incomes up to 200 percent of the federal poverty level for a family of four, which is \$40,000 in 2006, or who the Labor Department determines to be eligible for employment services under the federal Workforce Investment Act). DAS is required to award contracts to create four projects for janitorial work needed by State agencies.</p>
<b><i>Transportation</i></b>		
Whenever new housing resources are being developed for individuals with disabilities, consideration should be given to the availability of public transportation resources.		
Whenever new supportive employment opportunities are being developed for individuals with disabilities, consideration should be given to the availability of public transportation resources.		
Working collaboratively with individuals with disabilities, families, and providers, Connecticut should evaluate the existing transportation system and identify the gaps in services needed for persons with disabilities. The goal of this evaluation should be to improve the existing transportation system to achieve uniform	Under a grant from the Council on Developmental Disabilities (P.A.T.H.S.), the University of Connecticut Center on Disabilities is sponsoring a series of six regional forums with consumers with	Public Act 05-280 requires the Department of Social Services, during SFY 2005-2006, to provide grants to develop and plan financially self-sustaining community-based regional

<b>RECOMMENDATIONS</b>	<b>ADMINISTRATIVE and OTHER ACTIONS</b>	<b>LEGISLATIVE ACTIONS AND NEW FUNDING</b>
<p>coverage and to better meet the medical and social needs of Connecticut citizens with disabilities to allow them to participate fully in community life.</p>	<p>disabilities who use transportation services. A day-long Transportation Institute with consumers, legislators, policy makers and State agency representatives was held in November 2005. The intent of P.A.T.H.S. is to coordinate activities with the Connecticut Department of Transportation when a United We Ride facilitator is hired. Technical Advisory Committees will then be established to assist the State in the development and implementation of their State Human Services Transportation Action Plan.</p> <p>In May 2006 the Department of Social Services issued a Request for Application (RFA) Regional Transportation Systems. Proposals are due in June 2006</p>	<p>transportation systems for elderly persons, within existing budgetary resources. The grants are to go to four municipalities with populations of 25,000 or more or to a non-profit organization located within that size municipality and are not to exceed \$25,000 each.</p> <p>Public Act 06-188, Section 40 and 41, amends the community-based regional transportation system grant legislation by extending the program from one year (SFY 2006) to two years (SFY 2006 and 2007), removing the program funding cap of \$100,000, and increasing the amount of funding to a single grantee from \$25,000 to \$50,000 over the two year period. Grant funds are to be given to four municipalities or non-profit organizations to develop and plan financially self-sustaining community-based regional transportation systems that provide transportation services to elderly persons.</p> <p>Public Act 06-186 appropriates funds to subsidize transportation costs for Medicaid Adult Day Care. SFY 2006-2007: \$1,250,000</p> <p>Section 13b-38b (b) of the CT General Statutes was amended in SFY 2005 to provide for up to \$5 million in formula grants to municipalities to enhance the provision of demand-responsive transportation to seniors and people with disabilities. These state funded services are slated to begin starting on July 1, 2006.</p>

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
<b><i>Access to Information and Services</i></b>		
Complete construction of the Long-Term Care Website providing accessible information to all individuals in need of long-term care services and supports, regardless of age or disability. Over time, provide maintenance and ongoing updating of the Long-Term Care Website.	The Long-Term Care Website Steering Committee continues to meet on a monthly basis to complete development of the website.	
Explore the development of long-term care information resources for those consumers without Internet access.		
Over the next biennium and over time, distribute the Nursing Facility Transition Project (NFTP) handbook to all present and future Nursing Facility residents.	The NFTP continues to distribute the Nursing Facility Transition Guidebook to facility residents inquiring about transition. The guide and other materials are available on the state's DSS Website. An '800' number provides access to transition coordinators and the guidebook. The NFTP continues to explore ways to reach more residents. In October 2005 – a presentation on the NFTP and community option was presented at the annual Voices Conference. This conference, sponsored by the State Ombudsman for Long-Term Care is the annual conference for Presidents of Nursing Facility Resident Councils.	
Expand existing information and referral resources in order to establish and evaluate a Nursing Facility Transition Project hotline that will serve as an information resource for those interested in transitioning to the community.	A toll free hotline is operational in Connecticut for direct access to a transition coordinator.	
Initiate public/private partnerships to enhance public education regarding all aspects of the long-term care agenda in Connecticut. This should be done, in part, by building upon existing resources such as CHOICES and Infoline. Include	The Nursing Facility Transition Project together with the Connecticut Chapter of the National Association of Social Workers sponsored an Aging and Disability	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
<p>business, government, legislative, faith-based organizations, and community as well as consumer partners in this campaign to recognize strengths and needs of all individuals and families, to attract more workers to the health care arena, and to increase community concern and commitment to change.</p>	<p>Conference in November 2004. The 2004 Long-Term Care Plan served as the framework for the conference.</p> <p>CHOICES has established a website at <a href="http://www.medicareadvocacy.org">www.medicareadvocacy.org</a>. Click on the CHOICES icon.</p>	
<p><b><i>Quality of Life and Quality of Care</i></b></p>		
<p>Develop improved quality measures for persons with disabilities in the community under person-centered, consumer-directed programs. Such measures must reflect the individuals' own preferences and desires and allow reasonable risks while still avoiding unreasonable risks.</p>	<p>The Department of Mental Retardation (DMR) has redesigned its quality assurance system with the assistance of a grant from the federal Centers for Medicare and Medicaid Services (CMS). It is an outcome based model and integrates various quality assurance activities for analysis at the individual, provider and system level. DMR is testing the evaluation at selected sites in each DMR region.</p> <p>DMR designed a new Level of Need Assessment and Risk Screening Tool in SFY 2005-2006 with the assistance of a grant from CMS that improves the ability of the individual's support team to identify and manage risks.</p>	
<p>Utilize health promotion resources and initiatives outside of State government and attempt to coordinate the various efforts.</p>		
<p>Encourage further development of Visitation Programs for individuals and families in home, community and structured settings.</p>		
<p>Establish a working Fall Prevention partnership between the Department of Social Services (DSS) Aging Services Division and</p>	<p>The North Central Area Agency on Aging (NCAAA) has extensive programming in Fall</p>	

RECOMMENDATIONS	ADMINISTRATIVE and OTHER ACTIONS	LEGISLATIVE ACTIONS AND NEW FUNDING
the Department of Public Health (DPH) to expand current DPH fall prevention projects (i.e. home safety assessments, fall prevention seminars, medication safety programs, and fall prevention exercise classes) to serve new populations and geographic areas. Conduct social marketing, distribute public education materials, and utilize the media. Coordinate these activities with other existing Fall Prevention programs in the state.	Prevention and has collaborated with various hospitals and senior centers in their region.	
Explore opportunities to prevent the incidence, and delay the progression, of chronic diseases, such as better integration of the delivery of acute and long-term care across settings, use of prescription drugs, increased use of technology such as telemedicine, and increased patient education and self management.		Public Act 04-258 and Public Act 04-216 establishes a voluntary Dual Eligible Managed Care pilot for up to 500 individuals participating in both Medicare and Medicaid to encourage enrollment of dual eligible individuals into a Medicaid managed, capitated system for the acute portion of their benefit. A single entity would manage the care, regardless of payer. Net savings of \$50,000.  Public Act 06-186 appropriates funds to the Department of Social Services to enhance the Elderly Nutrition Program. SFY 2006-2007: \$800,000
Connecticut should support the purchase of assistive technology. Expenditures for assistive technology can be minor when compared to the extended cost of human services for personal assistance. This technology can allow an individual to maintain or regain independence and reduce their reliance on paid services.	The New England Assistive Technology (NEAT) project, through a contract with the Medicaid Infrastructure Grant, is working to establish a toll-free hotline for individuals, employers and professionals with questions about assistive technology. The first State Plan on Assistive Technology is due in 2005 and will be aligned with the State Long-Term Care Plan.	
Develop a plan to modernize the physical plants of existing nursing facilities.		
Expand the role of the Long-Term Care Ombudsman's Office to include other long-term care settings, such as assisted living		Public Act 04-158 requires the Office of the LTC Ombudsman, within existing

<b>RECOMMENDATIONS</b>	<b>ADMINISTRATIVE and OTHER ACTIONS</b>	<b>LEGISLATIVE ACTIONS AND NEW FUNDING</b>
facilities. Provide adequate funding for such an expansion.		appropriations, to implement a pilot program to provide services in Assisted Living facilities. Priority is given to residents in managed residential communities who participate in publicly subsidized assisted living programs.

**Status Report – June 2005**  
**“CHOICES ARE FOR EVERYONE” PLAN – ACTION STEPS**

The Long-Term Care Planning Committee will oversee the implementation of these action steps, including developing a timetable for completion of the action steps and assignment of who will be responsible for each step. In addition, the Planning Committee will review this Plan on a regular basis and revise it as necessary.

<b>ACTION STEPS</b>	<b>STATUS</b>
<b>Transition</b>	
<p>1. Develop a system to identify individuals who are residing in institutional care (restrictive environments) and want to live in the community.</p>	<p>Transition Coordinators under the Nursing Facility (NF) Transition Project provide formal and informal outreach to residents of nursing facilities.</p> <p>The conference in the fall of 2004 “Current Trends in Aging and Disability,” jointly sponsored by the CT System Change Grants and the National Association of Social Workers, was intended to provide outreach to facility Social Workers and others who are responsible for admission to, residency in and discharge from nursing facilities and other institutions. Information was presented on the Transition System developed by the NF Transition Project as well as workshops on community options and programs.</p> <p>The Department of Mental Retardation maintains formal records of individuals who request opportunities to leave institutional settings, and designates those individuals as a high priority (Priority 1) when allocating resources or making referral to community based options.</p> <p>In October 2005 – a presentation on the NF Transition Project and community options was presented at the annual Voices Conference. This conference, sponsored by the State Ombudsman for Long-Term Care is the annual conference for Presidents of Nursing Facility Resident Councils.</p>

<b>ACTION STEPS</b>	<b>STATUS</b>
2. Review guardianship and conservatorship laws, regulations, and training to determine what revisions would be necessary to make them consistent with the independent living model.	See Guardianship Report.
3. Educate people with disabilities who are in institutions and who will be transitioning out, about the importance of working with a peer who has made a successful transition to the community. The peer can provide practical advice about how to prepare for and deal with many of the difficulties of living in the community and provide assistance once the person gets out. For example, when people first transition out of an institution, they may have no friends or relatives to help them in the community and/or they may have little to do. This can be depressing. In addition, in order to successfully work with personal assistants who are not available 24-hours per day, people may need to train their bodies to be able to cope with the time periods between the personal assistance visits.	<p>The NF Transition Project sent a newsletter to all individuals who are in the transition system or who have transitioned in the Summer 2004. The focus was the importance of peer support in the transition process. Three Centers for Independent Living (West Haven, Hartford and Stratford) now have peer support groups for individuals in transition or who have transitioned from nursing facilities.</p> <p>The Community-integrated Personal Assistance Support Services (C-PASS) grant is piloting a peer training model to educate consumers regarding the hiring and management of personal assistants.</p>
4. Explore the possibility of developing a peer support network for people transitioning from living in institutions to living in the community. This is important because adjustment to living in the community is more than getting the physical care or mental health services from a paid provider.	<p>During 2004, the NF Transition Project contacted 30 organizations and developed informal agreements with 8 to form a statewide peer network for the benefit of people transitioning.</p> <p>Additional resources were obtained from the Developmental Disabilities Council and three support groups have been established statewide. As funding has ended, two support groups are currently functioning only informally.</p>
5. Educate people with disabilities that relying on paid support staff for 100 percent of their support needs will still leave them vulnerable. It is crucial to build on existing relationships where appropriate, and to develop strong new relationships with neighbors and members of the community.	<p>Circle of support is an important component of the transition system. As of June 2006, 78% of individuals in transition have a Circle of Support. 74% of individuals who have transitioned had a Circle of Support. Many of them have continued utilizing their circle as a support after transition.</p> <p>Utilization of Circle of Support continues. During its operation, the</p>

<b>ACTION STEPS</b>	<b>STATUS</b>
	<p>NFTP was linked to the Medicaid Infrastructure Grant which supports the Community Bridging Project.</p> <p>The Department of Mental Retardation places an emphasis on developing circles of support for all individuals who reside or wish to reside in the community or in their homes.</p>
<b>Housing</b>	
<p>1. Investigate how to improve the reporting of accessible housing units to the Connecticut Accessible Housing Registry. The current voluntary system has not produced the number of reported accessible units that are necessary for a successful registry.</p>	<p>See Housing Report.</p>
<p>2. Educate architects, housing authorities, builders, and local boards, such as <u>planning and zoning commissions</u>, about accessibility.</p>	<p>See Housing Report.</p>
<p>3. Convene a Task Force to review safety codes such as fire and building codes and recommend revisions designed to assure safety for individuals with functional limitations. Methods to follow-up and enforce these codes also needs to be reviewed.</p>	<p>See Housing Report.</p>
<p>4. Explore the possibility of providing tax or other incentives to encourage new homes or substantial renovations to meet minimum accessibility standards. This would apply to private homes as well as to public or private condominiums or apartments.</p>	<p>See Housing Report.</p>
<p>5. Strongly encourage every housing authority in the State to seek Section 8 certificates for people with disabilities when they are available.</p>	<p>See Housing Report.</p>
<p>6. Ensure that available Section 8 certificates are distributed to eligible families and individuals.</p>	<p>See Housing Report.</p>
<b>Supports</b>	
<p>1. Increase the paraprofessional support workforce through the creation and implementation of a strategic marketing plan to recruit personal</p>	<p>In collaboration with the C-PASS (Community-integrated Personal Assistance Support Services) and Medicaid Infrastructure grants</p>

<b>ACTION STEPS</b>	<b>STATUS</b>
<p>assistants and personal managers for permanent and backup employment.</p>	<p>contractual agreement was established with REWARDINGWORK.org in Massachusetts, a single point of access recruitment tool for recruiting personal assistants for permanent and backup employment. In 2005, 700 potential employees joined the REWARDINGWORK.org website as a result of outreach efforts. The total number of employees registered is currently over 1200.</p> <p>A brochure promoting personal assistance as a career was developed by a committee of consumers and personal assistants. 10,000 copies were printed and are being distributed throughout the state to One-Stops, Community Colleges, Independent Living Centers, Career Centers, Connecticut VETS Program, High School Guidance offices, etc. In addition, a series of Public Service Announcements are being broadcast through radio stations and on local Cable Access channels around the state. To date approximately 7,500 brochures have been distributed.</p> <p>Funded by the federal C-PASS grant, a recruitment video has been filmed and edited. This video focuses on demonstrating the benefits of choosing personal assistance as a career, through a series of interviews with personal assistants, their employers with disabilities and family members that illustrate the positive nature of the relationship between personal assistants and employers. The video is available in various formats, including DVD-Rs. The video has been converted for online access and can be linked with the following IP address: <a href="http://155.37.46.124/CPassPerAsst.wmv">http://155.37.46.124/CPassPerAsst.wmv</a>. It is also available on the HCBS website.</p>
<p>2. Develop and implement coordinated information source for backup personal assistants utilizing existing waiver program registries.</p>	<p>The C-PASS supported web-based recruitment website REWARDINGWORK.org is a source of back up as well as regularly employed personal assistants.</p>
<p>3. Encourage the “community team” (the team that comes together to assist the individual who is moving into the community) to continue</p>	<p>Circle of Support is an important component of the transition system.</p>

<b>ACTION STEPS</b>	<b>STATUS</b>
<p>to be involved with that individual for up to a year, if necessary, to deal with issues that could arise and increase the risk of re-institutionalization.</p>	<p>The transition program has been redesigned to provide a Circle of Support for up to six months. If still at risk, referral is made to the Bridges Project.</p> <p>As of June 2005, 76% on individuals in transition have a Circle of Support. 74% of individuals who have transitioned had a Circle of Support during the transition process. Many of them have continued utilizing their circle as a support after transition.</p>
<p>4. Work with Department of Labor to develop programs for displaced workers, clients of the Bureau of Rehabilitation Services, etc. to learn about personal assistance as a career.</p>	<p>Initial Contact Made.</p>
<p>5. Develop and make available optional training programs for individuals who want to support people with disabilities. Topics would include items such as meeting individual preferences of people with physical disabilities, meeting the special needs of individuals with mental health and mental retardation issues, communication with people who rely on non-verbal methods, and values associated with independent living.</p>	<p>Initial Contact Made.</p> <p>The DMHAS Education and Training Division provides several courses to staff that address the special needs of persons with mental illness. Examples of courses include motivational interviewing, employment practices, person-centered treatment planning, pharmacology, and recovery support.</p> <p>On May 16, 2006, DMHAS held a Recover Conference focusing on substance abuse and mental health recovery principles. Both concept of recovery and the delivery of effective recovery-oriented practice approaches were emphasized. The conference was attended by individuals in recovery, friends, families, providers, and policy makers.</p>
<p>6. Develop and implement training for people with disabilities who employ personal assistants regarding management of their employees. Management of employees includes hiring, coordinating personal assistants and their schedules, training personal assistants, completing the paperwork related to being an employer, working with a fiscal intermediary, developing and using effective relationship and communication skills, and terminating the</p>	<p>The NF Transition Project does this individually as people transition. As appropriate, individuals transitioning under the NF Transition Project are referred to the C-PASS Grant for additional training.</p> <p>Under the C-PASS (Community-integrated Personal Assistance Support Services) Grant to the University of Connecticut Center on Disabilities a comprehensive training manual and curriculum has been completed to</p>

<b>ACTION STEPS</b>	<b>STATUS</b>
employment of personal assistants when necessary.	<p>teach inexperienced or “novice” employers the skills to hire and manage personal assistants. Written by and for consumers, this training has been taught to teams of trainers (people with disabilities and their personal assistants). These teams are currently in the process of piloting the training to novice employers during and following their transition to the community in their own homes. A second group of consumers who receive services from the Department of Mental Retardation will be trained by September 2006 to be trainers in order to work with individuals and families who direct their own supports.</p> <p>The Department of Mental Retardation developed and published a Guide to Self-Direction which includes training on how to manage directly hired personal assistants in SFY 2005-2006.</p>
7. Educate the public about the availability of services provided by the Department of Transportation and specifically how to access those services.	This is done on a one-to-one basis as part of the transition process. Under a grant from the Connecticut Council on Disabilities (PATHS) the UCONN Center on Disabilities has conducted a series of forums on transportation issues that affect people with disabilities in Connecticut. A second series of forums is planned for the Fall of 2006 to educate consumers on existing transportation options and services.
8. Analyze the fiscal impact of providing a Connecticut income tax deduction for medical expenses that are deductible under the federal income tax.	Estimates range from \$11-15 million per year in lost revenue based on current federal medical expense deductibility rules.
<b>Community Connections</b>	
1. Distribute materials developed by the Nursing Facility Transition Project to the general public, current residents of institutions, and providers of supports such as physicians and their office staffs, pharmacists and their support staffs, hospital personnel, builders, and plumbers.	The NF Transition Project provides information to facility residents and the general public in formal and informal settings. During this year the project presented a t the annual conference of Presidents of Nursing Facility Resident Councils.
2. Develop and implement training for people to become bridge	NF Transition Project coordinated with the Medicaid Infrastructure

<b>ACTION STEPS</b>	<b>STATUS</b>
<p>builders, introducing people with disabilities to fellow community members who may become friends and support people.</p>	<p>Grant in November 2003 to pilot a bridging component advancing participation of people who have transitioned into the community.</p> <p>Coordination of efforts between the NF Transition Project and the Medicaid Infrastructure Grant continued with the Community Bridging Project advancing participation of individuals who have transitioned into community.</p>
<p>3. Assure that translators, interpreters for the deaf, and those skilled in interpreting for individuals with cognitive or communication issues are available to provide information and assistance.</p>	<p>The three Model Communities of the Real Choice Grant assure that appropriate accommodations are enforced. Additionally, education of other communities on this is being implemented, through the series of Regional Forums on Community Inclusion being held throughout the state. In September 2005 the Connecticut Real Choice conference on "Creating Inclusive Communities for Everyone" brought together over 140 town officials, professionals, community members and leaders with and without disabilities in a day of dialogue around the theme of inclusion and community change.</p> <p>The Department of Mental Retardation has included interpreter services in both Medicaid Waivers.</p>

**APPENDIX G.**  
**State Long-Term Care Programs**  
**SFY 2004 – 2005**

- I. Overview of State Agencies Providing Long-Term Care Services and Supports**
- II. State Long-Term Care Programs in Connecticut – SFY 2005**
- III. State Long-Term Care Program Expenditures in Connecticut – SFY 2005**

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

***Department of Social Services (DSS):*** DSS provides a broad range of services to people who are elderly or have disabilities, families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance, and independent living. It administers over 90 programs. By statute, it is the State agency responsible for administering a number of programs under federal legislation, including the Social Security Act (which includes Medicaid), the Rehabilitation Act, the Food Stamp Act and the Older American Act. DSS administers the Connecticut Home Care Program for Elders (CHCPE), a portion of which is State-funded, and other programs such as the Personal Care Assistance (PCA) Waiver Program, the Acquire Brain Injury (ABI) Waiver Program, the Katie Beckett Model Waiver Program, the Department of Mental Retardation Home and Community Based Waiver Program, the Connecticut AIDS Drug Assistance Program, and the Connecticut Pharmaceutical Assistance Contract to the Elderly (ConnPACE).

***Department of Mental Retardation (DMR):*** DMR provides case management, residential habilitation, individualized supports, campus settings, day habilitation, prevocational services, supported employment, respite care, family support and birth to three services to approximately 19,500 persons with mental retardation and their families. As of June 2006, 64.4 percent of those receiving services from DMR were served in their own homes, 4.1 percent lived in campus settings, 25 percent lived in public or private community living arrangements and 2.7 percent lived in community training homes, and 2.2 percent were in skilled nursing facilities.

***Department of Mental Health and Addiction Services (DMHAS):*** DMHAS has 18 Local Mental Health Authorities that provide a vast array of community mental health services for persons with mental illness. In addition, DMHAS operates inpatient hospitals and facilities for persons with severe addiction and/or psychiatric problems. DMHAS also contract with private not for profit agencies who provide an array of substance abuse and mental health services across the state. In SFY 2005, DMHAS served 45,480 persons with mental illness in the community and 2,112 persons with mental illness in inpatient facilities.

***Department of Economic and Community Development (DECD):*** DECD oversees all State statutes related to accessible housing. In addition to being a key partner in the assisted living demonstrations, it administers capital grants for the conversion of adaptable living units to accessible units for persons with disabilities. The agency is also responsible for a statewide registry of accessible housing.

***Department of Transportation (DOT):*** (DOT) provides about \$80 million a year in subsidies to bus and paratransit systems throughout the state. The fixed route bus system

provides discounted (half-fare) rides to seniors and people with disabilities. Out of a total of 37 million riders annually on the fixed-route system, about 2 million rides are provided annually to elderly and disabled customers. DOT administers the Federal Section 5310 program, which provides vehicle grants to municipalities and non-profit organizations. Over 100 vehicles funded by this grant program are operating around the state. In addition, the federal Americans with Disabilities Act (ADA) requires that demand-responsive paratransit services be provided to pre-qualified individuals who are not able, due to their disability, to utilize the local fixed-route bus system. ADA paratransit services are available to origins and destinations within 3/4 mile of the local bus route and are operated during the same days and hours as the local bus service. The State currently spends over \$10 million annually to support ADA services, and provides over 500,000 rides annually. The DOT-subsidized bus and paratransit operations serve 107 towns in the state.

***The Department of Public Health (DPH):*** The mission of DPH is to protect and improve the health and safety of the people of Connecticut. DPH is the state's leader in public health policy and advocacy. The Department is a partner to local health departments for which it provides advocacy, training and certification, technical assistance, consultation, and specialty services such as risk assessment that are not available on the local level. Additionally, DPH establishes health priorities and evaluates the effectiveness of health initiatives. The agency also has regulatory functions which focus on the quality of services provided by licensed professionals, health care institutions, child day care providers, laboratories, ambulances, and environmental health entities. Resources are also dedicated to epidemiology, vital statistics, health education, and surveillance.

***Department of Children and Families (DCF):*** DCF provides a variety of community-based and institutional services for children and adolescents with disabilities and their parents. The department's mandates include Prevention, Child Protection, Juvenile Justice Services and Behavioral Health. Services are provided through contracted providers as well as State operated facilities. DCF and DSS have formed the Behavioral Health Partnership to provide enhanced access to and coordination of a more complete and effective system of community-based behavioral health services and supports and to improve individual outcomes.

***Office of Protection and Advocacy for Persons with Disabilities (P&A):***

P&A is an independent State agency created to safeguard and advance the civil and human rights of people with disabilities. By providing various types and levels of advocacy assistance, P&A seeks to leave people with disabilities and their families better informed, equipped, and supported to advocate for themselves and others. In SFY 2005, the P&A provided information, referral, or short-term assistance to 5,967 people, while 1,046 individuals received a more intensive level of advocacy representation. P&A also investigated or monitored 1,029 investigations into reports of suspected abuse or neglect of adults with mental retardation, and provided training to over 2,000 individuals on disability rights topics.

***Board of Education and Services for the Blind (BESB):*** BESB offers a comprehensive array of services to improve the independent living skills of adults and children who are legally blind or visually impaired. Services are customized to each consumer's specific situation and include vocational counseling, technology training, teaching to improve activities of daily living, training in use of devices for safe travel, provision of low vision evaluations and aides, and self-advocacy training. Rehabilitation professionals are available to come to the homes, schools and places of employment of consumers, delivering specialized independent living, educational and vocational training. In addition, the agency Business Enterprises Program offers a unique opportunity for people who are blind to become entrepreneurs.

***Commission on the Deaf and Hearing Impaired (CDHI)*** – CDHI works to advocate, strengthen and implement state policies affecting deaf and hard of hearing individuals. Services and supports include: interpreting services for deaf and hard of hearing persons interacting with the public; counseling and assistance regarding many types of job related concerns; individual, marital, family and group counseling services to deaf and hard of hearing persons and hearing family members; and orientation seminars on deafness and deaf culture. There are approximately 204,334 hearing impaired people in Connecticut.

***Department of Veteran's Affairs (DVA)*** – DVA provides health care, residential and rehabilitative services for veterans honorably discharged from the Armed Forces. The Health Care Facility is licensed by the state DPH as a Chronic Disease Hospital and provides general medical care, physical therapy, occupational therapy, respiratory therapy, an Alzheimer unit, and hospice care. A new replacement Health Care Facility, serving 125 beds in total, is currently under construction with an anticipated completion date of January 2008. The Residential Facility is certified for 488 beds by the Federal Department of Veterans Affairs. In SFY05 the average monthly residential census was 324. Veterans receive substance abuse treatment, social work services, educational and vocational rehabilitation, job skills development, self-enhancement workshops, employment assistance and transitional living opportunities.

## II. State Long-Term Care Programs in Connecticut – SFY 2005

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DSS	Connecticut Home Care Program (CHCP)	Adult day health care Adult foster care Assisted living services Care management Chore services Companion services Home health aide services Home delivered meals Homemaker services Hospice services Info & referral MH counseling Minor home modifications Nursing services Nutritional services PCA services Personal emerg. response system Physical, speech, respiratory & occupational therapy Respite care Transportation	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living Alzheimer's facilities with private assisted living	Age 65 and over.  Must have at least one critical need (bathing, dressing, toileting, transferring, eating/feeding, meal preparation, medication administration).  Medicaid income limit = \$1,737/ month. Medicaid asset limit = Indiv \$1,600/ couple \$3,200. State funded income limit = no limit. State funded asset limit = Indiv \$19,020/ couple \$28,530 (one or both receiving services)	<u>Total Participants</u> Total - 14,845 Waiver - 10,089 State - 4,756  <u>Age</u> 65-84: 66.4% 85+: 33.4%  <u>Gender</u> male: 25.0% female: 75.0%  <u>Race/Ethnicity</u> W = 72.7% AA = 13.9% Hisp = 11.4% Asian = 0.7% Am Ind = 0.2%
DSS	Personal Care Assistance Waiver  Note: Information updated for SFY 2006	Personal care assistance services Personal emergency response system	Personal residences	Age 18-64.  Chronic severe and permanent disabilities.  Would otherwise require nursing facility care.	<u>Total Participants</u> 576 - monthly average during SFY 2006  <u>Age</u> N/A  <u>Gender</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
				<p>Capable of self-direction.</p> <p>Medicaid income limit = \$1,809/ month. Income in excess of 200% FPL applied to care.</p>	<p><u>Race/Ethnicity</u> N/A</p>
DSS	Acquired Brain Injury Waiver (ABI)	<p>Case-management Chore Cognitive behavioral program Community living supports Companion Day Habilitation Durable medical equipment Family training Homemaker services Home delivered meals Independent living skill training Information and referral Personal care assistance Personal emergency response system Pre-vocational services Respite care Substance abuse Supported employment Transportation Vehicle modification Transitional living</p>	<p>Personal care residence Group residence</p>	<p>Age 18-64.</p> <p>Brain injury that is not a result of a developmental disability or degenerative condition.</p> <p>Dysfunction is not primarily the result of a mental illness.</p> <p>Would otherwise be institutionalized.</p> <p>Medicaid income limit = Less than 200% FPL.</p> <p>Medicaid asset limit = Individual \$1,600</p>	<p><u>Total Participants</u> 290</p> <p><u>Age</u> 18-49: 212 50+: 77</p> <p><u>Gender</u> Male: 208 Female: 82</p> <p><u>Race/Ethnicity</u> N/A</p>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DSS	Katie Beckett Model Waiver	Case management & Medicaid State Plan services	Personal Residences	Birth to 64 years old  Would otherwise require care in a nursing home or ICF/MR.  Medicaid income limit = \$1,692. Medicaid asset limit = \$1,000. Income of parent or spouse not counted.	<u>Total Participants</u> 125  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DSS	Breakthrough to the Aging  Note: Information updated for SFY 2006	Companion Transportation Grocery shopping	Personal residences Congregate housing Elderly housing	Age 60 and over.  Clients must be homebound and request services.	<u>Total Participants</u> Volunteers - 300 New clients - 125  <u>Age</u> Volunteers - N/A Clients - Age 60 +  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DSS	Seniors Helping Seniors  Note: Information updated for SFY 2006	Volunteers may shop for clients, provide transportation to shopping or medical appointments, provide some budgeting assistance or escort their clients to the doctor's office.  Volunteers also act as advocates, linking their clients to appropriate community services.	Personal residences Doctor's offices Hospitals Shopping centers	Age 60 and Over.	<u>Total Participants</u> Volunteers - 36 Clients - 300
DSS	CHOICES  Note: Information updated for SFY 2006	Health insurance counseling Information & referral	Senior Centers Libraries Personal residences Elderly housing Assisted living Hospice facilities Nursing facilities Area Agencies on Aging	Age 60 and over.  Under 60 if Medicare eligible.	<u>Total Participants</u> Individual Clients - 62,362  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DSS	MediSave  Note: Information updated for SFY 2006	Information & referral Train the trainer	Congregate housing Elderly housing Assisted living Senior centers	N/A	<u>Total Participants</u> Volunteers - 144  Presentations – 76  Beneficiaries who attended presentations – 1,839  Reached by

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
					community education events – 43,612  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DSS	Home Share Programs  Note: Information updated for SFY 2006	Home sharing for adults in exchange for a monetary contribution or performance of services such as housekeeping, shopping, etc.  Contractor provides housing counseling for all applicants, enrolls appropriate people in the home share program, and matches compatible people to share a home.	Private homes	At least one adult in a match must be over the age of 60.	<u>Total Participants</u> 475 people counseled  69 people enrolled in home share program  7 matches made  <u>Age</u> 60+: 189 75+: 134
DSS	CT Partnership for Long-Term Care - Information & Education Program  Note: Information updated for SFY 2006	Information & referral One-on-one counseling Regional public forums	Personal residences Libraries Schools Senior Centers	Age 18-89	<u>Total Participants</u> Calls for information - 702  Individuals counseled - 295  Attended public forums - 515

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
					<u>Age</u> 44-66 attended forums  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DSS	Statewide Respite Care Program (for persons with Alzheimer's or related dementia)  Note: Information updated for SFY 2006	Adult day care Care management Chore services Companion services Counseling Home health aide services Home delivered meals Homemaker services Information & referral Nursing services Personal emerg. response system Short-term respite care Information and referral Support groups	Personal residences Adult day care centers Congregate housing Elderly housing Residential care homes Assisted living for short-term respite Hospice facilities Nursing facilities	No age requirement.  Alzheimer's or a related dementia.  \$30,000 income \$80,000 assets  Co-pay of 20% of cost of service required (may be waived upon financial hardship)	<u>Total Participants</u> 556  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DSS	Retired Senior and Volunteer Program  Note: Information updated for SFY 2006	Information & referral Volunteer services	Schools, airports, state institutions, community social agencies, police departments	Age 55 and over.	<u>Total Participants</u> Volunteers - 5,601  <u>Age</u> < 60: 120 60-74: 3,342 75+: 2,139  <u>Gender</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
					<u>Race/Ethnicity</u> N/A
DSS	Supportive Services and Health and Wellness: Older Americans Act Title IIIB and Title IIID	Adult day care Care management Chore services Companion services Home health aide services Homemaker services Hospice services Information & referral Mental health counseling Nursing services PCA services Personal emerg. response system Recreation services Respite care Transportation Medication monitoring	Area Agencies on Aging Personal residences Adult day care centers Congregate housing Elderly housing	Age 60 and over.	<u>Total Participants</u> 49,475  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DSS	Elderly Nutrition Program: Older Americans Act Title IIIC and State Nutrition	Nutritionally balanced meals served through congregate meal sites and home delivery	Senior Community Cafes Residential Homes	Age 60 and over and their spouses/caregivers	<u>Total Participants</u>  Congregate meals: 999,487 meals served to 15,539 participants  Home delivered meals: 1,511,039 meals served to 8,037 participants

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DSS	CT's National Family Caregiver Support Program: Older Americans Act Title III E	Adult day care Assistive devices/ Supplemental services Care management Chore services Home health aide services Homemaker services Information & referral Personal emergency response system Transportation Grandparents support Support groups	Personal residences Adult day care centers Elderly housing Nursing facilities (for short term respite only)	Care recipient must be age 60 and over.  Two or more ADL limitations.  Children 18 yrs of age or younger for grandparent support.	<u>Total Participants</u> Respite – 1,239 Supplemental services – 630 One-on-one assistance – 7,681 Counseling, support groups, training – 1,431  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DSS	Congregate Housing Services	Adult day care Care management Chore services Companion services Home health aide services Information & referral Nutritional services Personal care attendant services Personal emergency response system Transportation Medication monitoring Foot care	Congregate housing	Age 60 and over.  Frail with temporary or permanent disabilities.	<u>Total Participants</u> 182  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DSS	Senior Community Service Employment Program  Note: Information updated for SFY 2006	Information & referral Employment & training	Community (AAA, Community Action Agencies, municipalities, community-based orgs.)	Age 55 and over.  Income not exceeding 125% of the federal poverty level.	<u>Total Participants</u> 182  <u>Age</u> 55-64: 118 65-84: 64  <u>Gender</u> male: 63 female: 119  <u>Race/Ethnicity</u> W = 123 AA = 56 Hisp = 20 Asian = 3 Am Ind = 2
DSS	Medicare Legal and Education Assistance Project  Note: Information updated for SFY 2006	Health insurance counseling Information & referral Legal representation for Medicare appeals	Not setting specific	Medicare eligible by virtue of age or disability.	<u>Total Participants</u> 5,092 direct client assistance  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DSS	Elderly Health Screening Program  Note: Information updated for SFY 2006	Mental health screening/ counseling Nutrition education Health promotion/ wellness education	Personal Residences Congregate Housing Elderly Housing Any community setting Community Health Centers	Age 60 and over.	<u>Total Participants</u> 3,500  <u>Age</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
		Geriatric assessment Health screening: breast, prostate, cholesterol, eye, cardiovascular, etc. Foot care	Public Health Departments		<u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DMR	Home and Community-Based Services Waiver	Personal support Individual support and habilitation Adult companion services Group day services Individualized day services Respite care Residential habilitation Supported employment services Environmental accessibility adaptations Personal emergency response system (PERS) Transportation Vehicle modifications Specialized medical equipment and supplies IFS family training	Personal residences Community living arrangement Community training home Community day program site Community employment	Individuals over the age of three.  Person with mental retardation needing ICF/MR level of care.  Medicaid program: Income less than 300% of SSI and assets less than \$1600.	<u>Total Participants</u> 7,332  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DMR	Intermediate Care Facility for the Mentally Retarded (ICF/MR)	Residential habilitation Day habilitation Prevocational services Supported employment services	ICF/MR	No age limit.  Person with mental retardation needing ICF/MR level of care.  Medicaid program: Income less than 300% of SSI and assets less than \$1600.	<u>Total Participants</u> 861  <u>Age</u> 0-18: 0 19-54: 488 55-64: 252 65+: 161  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DMHAS	Case management-Mental Health	Info & Referral Transportation Case management	Personal Residences RCH NF Shelters Supportive housing sites Psychosocial clubs	Adults age 18 and over.  Primary diagnosis of a psychiatric disorder; Requires assistance in obtaining and coordinating treatment, rehabilitation, and social services without which the individual would likely require a more intensive level of care.  No private insurance to pay for comparable services.	<u>Total Participants</u> 7,672  <u>Age</u> 0-18: 34 19-54: 6,021 55-64: 332 65-84: 415 85+: 4  <u>Gender</u> male: 3,694 female: 3425  <u>Race/Ethnicity</u> W = 4,815 AA = 1,187 Hispanic = 1,936 Asian = 61 Am Ind = 27

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DMHAS	Assertive Community Treatment (ACT)	A set of clinical, medical & psychosocial services, provided on a one-to-one basis, essential to maintaining an individual's ability to function in community settings. Services available 24/7.	Personal residences Community settings	<p>Adults age 18 and over.</p> <p>Primary diagnosis of a psychiatric disorder; Would otherwise require more intensive and restrictive services.</p> <p>No private insurance to pay for comparable services.</p>	<p><u>Total Participants</u> 3,259</p> <p><u>Age</u> 0-18: 22 19-54: 2,784 55-64: 385 65-84: 96 85+: 0</p> <p><u>Gender</u> male: 1,860 female: 1,398</p> <p><u>Race/Ethnicity</u> W = 1,834 AA = 688 Hisp = 777 Asian = 31 Am Ind = 11</p>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DMHAS	Mental Health Intensive Outpatient Services	Individual, group or family psychotherapy; Psycho-educational groups; Classes on ADLs; Recovery oriented services.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, psychiatric outpatient clinic for adults, or a State-operated facility.	<p>Adults age 18 and over.</p> <p>Primary diagnosis of a psychiatric disorder; Behavior does not pose an imminent risk of harm to self and other; Living environment can assure a reasonable degree of safety; Symptomology/behavior warrants an increase in frequency and/ or intensity of clinical contact in an effort to stabilize the individual.</p> <p>No private insurance to pay for comparable services.</p>	<p><u>Total Participants</u> 413</p> <p><u>Age</u> 0-18: 4 19-54: 368 55-64: 32 65-84: 9 85+: 2</p> <p><u>Gender</u> male: 165 female: 248</p> <p><u>Race/Ethnicity</u> W = 257 AA = 36 Hisp = 73 Asian = 2 Am Ind = 4</p>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DMHAS	Mental Health Outpatient Clinical Services	Individual, group or family counseling; Education to client and family; Support with connecting to/referral to natural community supports; Assistance with obtaining/maintaining employment.	Non-residential services provided in a general hospital, private free-standing psychiatric hospital, a State-operated facility, a facility licensed by DPH to offer "outpatient treatment," or by a private independent psychiatrist or psychologist or private group practice.	Adults age 18 and over.  Primary diagnosis of a psychiatric disorder.  No private insurance to pay for comparable services.	<u>Total Participants</u> 25,389  <u>Age</u> 0-18: 260 19-54: 20,030 55-64: 3,366 65-84: 1,578 85+: 200  <u>Gender</u> male: 11,038 female: 14,343  <u>Race/Ethnicity</u> W = 15,045 AA = 2,894 Hisp = 5,333 Asian = 327 Am Ind = 198
DMHAS	Mental Health Residential - Group Home	Rehabilitative support focusing on areas of self-care and independent living skills.	Group home	Adults age 18 and over.  Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of self-care and independent living as a result of the psychiatric disability.  No private insurance to pay for comparable services.	<u>Total Participants</u> 327  <u>Age</u> 0-18: 4 19-54: 289 55-64: 30 65-84: 4 85+: 0  <u>Gender</u> male: 205 female: 122  <u>Race/Ethnicity</u> W = 206

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
					AA = 74 Hispanic = 46 Asian = 1 Am Ind = 1
DMHAS	Mental Health Residential - Supervised Housing	Supportive counseling directed at solving day to day problems with community living; Psycho-education groups; Assistance with employment; Rehabilitative support.	Supervised housing	Adults age 18 and over.  Primary diagnosis of a psychiatric disorder; Significant skill deficits in the area of independent living as a result of severe and persistent mental illness.  No private insurance to pay for comparable services.	<u>Total Participants</u> 1,008  <u>Age</u> 0-18: 5 19-54: 844 55-64: 126 65-84: 36 85+: 1  <u>Gender</u> male: 587 female: 421  <u>Race/Ethnicity</u> W = 669 AA = 199 Hispanic = 115 Asian = 2 Am Ind = 6

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DMHAS	Mental Health Residential - Supported Housing	Supportive counseling directed at solving day to day problems with community living; Psycho-education groups; Assistance with employment; Teaching/ coaching of daily life skills.	Supportive housing	<p>Adults age 18 and over.</p> <p>Primary diagnosis of a psychiatric disorder; Moderate skill deficits in the area of independent living as a result of the psychiatric disability.</p> <p>No private insurance to pay for comparable services.</p>	<p><u>Total Participants</u> 2,480</p> <p><u>Age</u> 0-18: 3 19-54: 2,122 55-64: 310 65-84: 82 85+: 6</p> <p><u>Gender</u> male: 1,257 female: 1,223</p> <p><u>Race/Ethnicity</u> W = 1,166 AA = 424 Hisp = 496 Asian = 29 Am Ind = 23</p>
DMHAS	Psychosocial Rehabilitation	Independent living and community reintegration skill development.	Community setting	<p>Adults age 18 and over.</p> <p>Primary diagnosis of a psychiatric disorder; Moderate impairment in vocational, educational and/or social functioning; Needs assistance with at least 2 ADLs.</p> <p>No private insurance to pay for comparable services.</p>	<p><u>Total Participants</u> 7,315</p> <p><u>Age</u> 0-18: 21 19-54: 6,042 55-64: 1,038 65-84: 229 85+: 12</p> <p><u>Gender</u> male: 4,306 female: 3,009</p> <p><u>Race/Ethnicity</u> W = 4,611</p>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
					AA = 1,474 Hisp = 1,080 Asian = 62 Am Ind = 43
DMHAS	Crisis Stabilization Beds (respite)	Short-term residential services to help stabilize a rapidly deteriorating behavioral health condition and avert hospitalization.	A facility of not more than 15 beds staffed 24/7.	Adults age 18 and over.  Primary diagnosis of a psychiatric disorder; Increased exacerbation of symptoms within the past 24 hours; Does not present as an imminent safety risk to self or others consistent with criteria for inpatient psychiatric care.  No private insurance to pay for comparable services.	<u>Total Participants</u> 619  <u>Age</u> 0-18: 9 19-54: 566 55-64: 39 65-84: 9 85+: 2  <u>Gender</u> male: 355 female: 264  <u>Race/Ethnicity</u> W = 376 AA = 135 Hisp = 133 Asian = 3 Am Ind = 4
DMHAS	Mobile Crisis Services	Psychiatric evaluation; Psychiatric stabilization; Brief clinical treatment; Medication evaluation; Hospital pre-screening.	Personal residences Congregate housing Elderly housing Residential care homes Nursing facilities Shelters On the streets	Adults age 18 and over.  Primary diagnosis of a psychiatric disorder; Presentation of symptoms/ behaviors that place the individual at risk to self or others.	<u>Total Participants</u> 10,464  <u>Age</u> 0-18: 194 19-54: 8,991 55-64: 784 65-84: 422 85+: 115

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
				No private insurance to pay for comparable services.	<u>Gender</u> male: 5,428 female: 5,036  <u>Race/Ethnicity</u> W = 6,281 AA = 1,549 Hisp = 2,672 Asian = 66 Am Ind = 43
DMHAS	Long-Term Psychiatric Hospitalization	Medication evaluation; Individual/ group counseling; Specialized treatment services.	Psychiatric hospital	Adults age 18 and over.  Primary diagnosis of a psychiatric disorder; Chronic risk of being a danger to self or to others or chronic grave disability as a result of the psychiatric disorder.  No private insurance to pay for comparable services.	<u>Total Participants</u> 1,709  <u>Age</u> 0-18: 62 19-54: 1,404 55-64: 75 65-84: 7 85+: 2  <u>Gender</u> male: 1,110 female: 599  <u>Race/Ethnicity</u> W = 947 AA = 374 Hisp = 369 Asian = 22 Am Ind = 4

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DMHAS	Substance Abuse Residential - Long-Term Care	Clinical/ therapeutic services Individual/ group counseling Psychosocial programming Relapse Prevention Employment skill development	Structured recovery environment	Adults age 18 and over.  General Assistance recipients with significant problems with behavior and functioning in major life activities due to substance abuse.	<u>Total Participants</u> 199  <u>Age</u> 0-18: 0 19-54: 183 55-64: 13 65-84: 3 85+: 0  <u>Gender</u> N/A  <u>Race/Ethnicity</u> W = 61 AA = 27 Hisp = 107 Asian = 1 Unknown = 3
DECD	Congregate Operating Subsidy Program	Assisted living services Care management Chore services Companion services Health insurance counseling Info & referral Nutritional services PCA services Recreation services Transportation	Congregate housing	Age 62 and over and frail.  One ADL minimum.  Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	<u>Total Participants</u> 951 residents  <u>Age</u> 65+: 951  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DECD	Elderly Rental Registry and Counseling	Funds provided to hire a Resident Service Coordinator to assist residents of State-funded elderly facilities.	Elderly Housing	N/A	<u>Total Participants</u> 2,505 units in 36 facilities  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DECD	Elderly Rental Assistance Program	Financial Assistance to make rents affordable to low/ moderate income elderly.	Personal residences	Age 62 and over or disabled.  Certified disabled by Social Security Board or other federal board or agency as being totally disabled.  Annual income cannot exceed the "Low Income" for the area adjusted for family size as defined by HUD.	<u>Total Participants</u> 1,416  <u>Age</u> 0-64: 457 65+: 959  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DECD	Housing Assistance and Counseling	Assisted living services Info and referral	Elderly Housing (federal 202 or 236)	Age 62 and over.  Requires assisted living services (at least 1 ADL) as determined by Care Plan.	<u>Total Participants</u> 59  <u>Age</u> 65+: 59  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DOT	Local Bus Services	Transportation (Local bus at half fare)	Community	All ages  Seniors and people with a qualifying disability.	<u>Total Participants</u> 1,750,000 passenger trips (of 35,000,000 total trips)  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DOT	ADA Paratransit Van Services	Transportation	Community (within 3/4 mile of local public bus routes)	All ages  Any person with a disability who is unable, due to physical or mental impairment, and without the assistance of another individual, to board, ride or disembark from any public local bus. Also for those with a specific impairment-related condition that prevents them from traveling to or from a bus stop.	<u>Total Participants</u> Over 18,000 registered users  <u>Age</u> N/A  <u>Gender</u> N/A  <u>Race/Ethnicity</u> N/A
DPH	Facility Licensing and Investigations Section (FLIS)	Regulatory jurisdiction for state licensing programs. Conducts surveys/ investigations of health care entities that participate in Medicare and Medicaid.	Nursing Homes Residential Care Homes Hospitals Outpatient Clinics Dialysis Units Ambulatory Surgical Facilities Substance Abuse and Mental Health Facilities Home Health Agencies Assisted Living Services Agencies	Institutions identified under CGS 19a-490.  Medicare and Medicaid entitlement enrollment is a voluntary participation program open to various types of providers.	N/A

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DPH	Health, Education Management Surveillance Section (HEMS)	<p>Addresses all types of injuries, including fall prevention.</p> <p>Provides educational materials and technical assistance to the public.</p>	Local health offices offer onsite programs at various locations such as home safety visits, exercise programs.	<p>Individuals may request information from DPH's HEM Section.</p> <p>Availability depends upon the local health department's resources.</p>	<u>NA</u>
DVA	Veterans' Health Care Services	<p>Provides a continuum of health care, social and rehabilitative services including:</p> <p>General medical and nursing care Alzheimer's and dementia care Hospice and respite care Physical, occupational and respiratory therapy Long-term substance abuse rehabilitation program</p>	Health care facility (onsite)	Veterans as defined by CGS 27-103 who served honorably and are residents of Connecticut	<p><u>Average Monthly Census</u> 153</p> <p><u>Age</u> N/A</p> <p><u>Gender</u> N/A</p> <p><u>Race/Ethnicity</u> N/A</p>
DVA	Residential and Rehabilitative Services	<p>Provides domiciliary level of care to facilitate rehabilitation and return to independent living including:</p> <p>Residential services General medical care Substance abuse treatment Social work services Educational support Employment skill development</p>	Residential domicile (onsite)	Veterans as defined by CGS 27-103 who served honorably and are residents of Connecticut	<p><u>Average Monthly Census</u> 324</p> <p><u>Age</u> N/A</p> <p><u>Gender</u> N/A</p> <p><u>Race/Ethnicity</u> N/A</p>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DCF	Care Coordination	<p>Provides both a service to children and families and is a function of a responsive system. As a service, care coordination is carried out in children's mental health in Connecticut on three levels depending on the needs of the child and family;</p> <p>Level I: for a child/youth involved in only one service component. The child's service provider or a member of the multi-disciplinary team assigned to the child is responsible for care coordination in partnership with family.</p> <p>Level II: for a child/youth who has a DCF worker. The child's worker serves as the Care Coordinator in liaison with the child's primary service provider or member of the assigned multi-disciplinary team.</p> <p>Level III: for a child/youth involved in multi-agencies, and identified as needing Care Coordination independent of any particular service received. Here, care coordination is done by a full-time Care Coordinator through the Systems of Care/Community</p>	Local offices in 8 towns provide referral, consultation, home visits, and services to address a wide range of behavioral health issues statewide.	Families may self refer or referrals are received from DCF and other community providers.	<p><u>Birth to age eighteen Services can be received up to age 21 if client is still receiving services from their local educational authority.</u></p> <p><u>Capacity to serve 1500 families per year.</u></p>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
		<p>Collaboratives (when/where there are available funds for a full-time Care Coordinator) In addition, care coordination is performed by the DCF caseworker in conjunction with the System of Care/Community Collaborative Care Coordinator when a family is involved with the Department.</p>			
DCF	Children with Complex Medical Needs – Foster Care	Foster Care for a small population of children that have medical needs beyond the common childhood illnesses.	Foster Homes - Some children may have the need for special medical equipment.	Children and youth placed in the custody of DCF voluntarily or involuntarily	<u>Birth to 18</u>  <u>SFY 2005 – 268 foster homes were active</u>
DCF	Community Life Skills	<p>The Community Based Service Model for life skills training is one of the components of the Community Life Skills Program.</p> <p>The central focus of the community-based program is the development and/or enhancement of the participant's knowledge of essential life skills to promote preparation for adulthood and self reliance.</p> <p>Through program design and content, it provides</p>	Varied settings within the community.	DCF involved youth residing in out of home placement within the community.	<u>Adolescents and Young Adults</u> <u>ages 15-21</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
		youth with the opportunity for learning, problem solving, and enhancement of self esteem.			
DCF	Community Emergency Services:  Emergency Mobil Psychiatric Services  Emergency Mobil Services (EMS)/Care Coordination	This service provides emergency services including mobile response; psychiatric assessment; medication consultation, assessment, and short-term medication management; behavioral management services; substance abuse screening and referral to traditional and non-traditional services for any family with a child in crisis.	Statewide Community Providers providing emergency referrals, and consultation.	Statewide EMPS providers have a centralized, toll-free phone number to serve as a point of entry and to provide person-to-person assistance and connection to crisis services. The centralized number is accessible 24 hours per day, 7 days per week, 365 days per year. In the event of a psychiatric emergency, a trained screener will, within 15 minutes, facilitate direct contact with a licensed EMPS staff member or other emergency service as necessary.	<u>Children and Youth ages 5-18</u>
DCF	Connecticut Children's Place (CCP)	Provides diagnostic, brief treatment, residential care and educational instruction for abused and neglected children between the ages of 10 and 18 from all over the state.	Residential - Children live in three cottages, each with a capacity for 14 children.	Children placed in the custody of DCF voluntarily or involuntarily	<u>Youth, and adolescents ages 10-18</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DCF	Crisis Stabilization Beds	Crisis stabilization is a 24 hour, short term residential program that offers the child and family a “cooling off” period from a particular crisis. This short term intervention is designed to enable crisis stabilization staff an opportunity to make good, appropriate assessments and interventions that may prevent a longer out of home disruption.	There are two crisis stabilization programs in Connecticut. One located in Farmington on the UCONN Medical Center Campus a program of Wheeler Clinic and one in Hamden a program of the Children’s Center.	Crisis stabilization will accept all referrals made by Emergency Mobile Psychiatric Service (EMPS) providers that follow a certain criteria.	<u>Children, Youth, and adolescents ages 7-18</u>
DCF	Emergency Shelters	Providing emergency placement of children and youth until the most appropriate placement is located for the child or youth.	Facilities can have up to 20 beds	Children placed in the custody of DCF voluntarily or involuntarily	<u>Youth, and adolescents ages 9-18</u>
DCF	Extended Day Treatment	A community-based program that offers a structured, intensive, therapeutic milieu with integrated clinical treatment services. Services are provided year round during non-school hours for an average period of six months.	Schools, child guidance clinics, hospitals, residential programs.	Families may self refer or referrals are received from DCF and other community providers. A candidate for admission to an EDT program must meet the Intermediate Level of Care criteria, as defined in the Connecticut Behavioral Health Partnership’s Guidelines for Making	<u>Youth, and adolescents ages 5-17</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
				Level of Care Decisions.	
DCF	Family Support Team	Family Support Teams provide an array of intensive treatment and support services to children, youth and families in their homes and communities.	Services are delivered in the home and community, and may be provided for an indeterminate length of time. FST staff also provide 24-hour/7-day emergency crisis response.	FST services are currently available only to children and families with DCF-involvement. Referrals to FST are made by the DCF Area Offices.	<u>Youth, and adolescents ages 9-18</u>
DCF	Family Violence Outreach	Providing support, advocacy, education, and case management services to families dealing with issues of domestic violence	Statewide offices to provide referral, consultation, home visits, and services to address a wide variety of domestic violence issues.	Families may self refer or referrals are received from DCF and other community providers	<u>NA</u>
DCF	Foster Care: (Relative and Non-Relative)	Provides a family environment for children who are temporarily unable to live in their biological homes. Together with other services provided to foster parents, families and children, these homes facilitate the reunification of children with their families or establish another permanent family for the children.	Home Settings Statewide	Children, Youth, and Adolescents in the care and custody of DCF	<u>Birth to 18</u> <u>SFY 2005 – 3247 active foster homes</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DCF	Foster Care Supports	Providing support, advocacy, education, and case management services to foster families in the attempt to maintain a child's placement. Also, collaboration with Connecticut Association of Foster and Adoptive Parents (CAFAP)	Varied settings within the community depending on activity. (counseling, sports, in-home therapy, aftercare services, social activities, etc.)	DCF Foster Families	<u>NA</u>
DCF	Group Homes	Provides a continuum of living options for youth ages 14 and up moving toward successful adulthood, the goal being the least restrictive, most community-based possible. They will focus on life skills programming, educational planning along with vocational planning.	Community home-like settings with multiple staff.	Youth in the care and custody of DCF	<u>Youth ages 14-18</u>  <u>Average Capacity is 6-10 youths</u>
DCF	High Meadow	Provides residential treatment for severely emotionally disturbed adolescents who require intensive and comprehensive services, but who do not require the most restrictive environment available (i.e., closed setting).	Residential -42 beds providing treatment that can only be effected in a setting which protects the youth and/or community in a 24-hour a day structured program.	Children placed in the custody of DCF voluntarily or involuntarily	<u>Youth, and adolescents ages 12-17</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DCF	<p>Independent Living Program:</p> <p>Community Housing Assistance Program (CHAP)</p> <p>Transitional Living Apartment Program (TLAP) programs.</p>	<p>Youth live in a semi-supervised subsidized housing environment, which includes receive case management services that promotes the acquisition of independent living skills, educational, vocational, pre-employment, and job placement opportunities.</p>	<p>Varied settings within the community</p>	<p>Youth who have been or return to state care may be eligible to receive housing support.</p>	<p><u>Youth ages 18-23</u></p>
DCF	<p>Intensive Home Based Services – Functioning Family Therapy (FFT)</p>	<p>Family Support Teams offer intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties.</p>	<p>Provides home-based treatment to children, youth and families in their homes and communities.</p>	<p>Eligibility for FST services does not require DCF-involvement. Referrals to FST are typically made by the DCF Area Offices, System-of-Care Collaboratives, and community providers.</p>	<p><u>Youth, and adolescents ages 9-18</u></p>
DCF	<p>Intensive Home Based Services: Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS), Multidimensional Family Therapy (MDFT), and Multisystemic Therapy (MST)</p>	<p>IICAPS offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. MDFT offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to substance abuse or</p>	<p>Provides home-based treatment to children, youth and families in their homes and communities. Services are typically delivered for an average of 5 to 6 months. All service staff also provide 24-hour/7-day emergency crisis response.</p>	<p>Eligibility for all programs does not require DCF involvement. Referrals to all programs are typically made by the DCF Area Offices, System-of-Care Collaboratives, Juvenile Justice staff, inpatient psychiatric hospitals or community providers</p>	<p><u>Youth, and adolescents ages 9-15</u></p>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
		co-occurring disorders. MST offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to problems of delinquency, disruptive behavior and/or substance abuse.			
DCF	Lifelong Family Ties Project	A child centered program that moves outward from the child's perception of people important to him/her to identify life connections through current and past family and community ties. The goal of the program is to create life long connections for the child in the following way: either through a permanent placement resource, a mentoring relationship, a supportive relationship and/or other positive connections to the child's kin network.	Varied settings within the community. Currently 2 local providers.	Children/youth identified for this program are those who have been legally free for adoption and for who past efforts at finding an adoptive family have been unsuccessful for a year or more.	<u>Children, Youth, and adolescents ages 5-18</u>  <u>Capacity to serve approximately 50 children per year.</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DCF	Outpatient Adolescent Substance Abuse Treatment	Services shall include but not be limited to diagnostic evaluation, family, group and individual therapies, medication services, crisis or emergency interventions to assist families and youth with substance abuse use and dependence.	Home and community settings statewide	Families may self refer or referrals are received from DCF and other community providers	<u>Youth ages 14-18</u>
DCF	Positive Youth Development	Nine statewide contractors are promoting this initiative to accomplish three main goals in their communities; Select an evidence-based or promising practices positive youth development prevention program in a small community; 2) Support parents in their role as parents; 3) Provide recreational and enrichment opportunities for children participating in the program and their families.	Home and community settings statewide	Families may self refer or referrals are received from DCF and other community providers	<u>NA</u>
DCF	Residential Care Facilities	Facilities are 24-hour mental health facilities that operate for the purpose of effecting positive change and normal growth and development for emotionally disturbed, behaviorally disordered, and socially maladjusted youth.	Clinical settings state and nationwide	Youth are referred through a holistic treatment plan, involving DCF staff and mental health professionals.	<u>Adolescent females and males age 13-17</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DCF	Respite Care Services	Provide home care, thus avoiding “burnout,” reducing stress and preventing family disruption (or out-of-home placement) of the child/adolescent with serious emotional disturbances and to provide socialization opportunities and age appropriate activities for children as specified in the child/youth’s treatment/service plan.	Home and community settings statewide	Referrals made by DCF or community System of Care Coordinator	<u>Children 6- 18 years old</u>  <u>Capacity to serve 350 children per year</u>
DCF	Riverview Psychiatric Hospital	The hospital provides comprehensive care to children and adolescents with severe mental illness and related behavioral and emotional problems who cannot be safely assessed or treated in a less restrictive setting.	Hospital	Children placed in the custody of DCF voluntarily or involuntarily	<u>Youth, and adolescents ages 9-18</u>
DCF	Safe Homes	The purpose of a SAFE Home is to provide a safe and stable environment for children who experience out-of-home placement for the first time. SAFE Homes should facilitate keeping sibling groups together, provide the opportunity for children to remain in close proximity to their own communities and allow children to attend their own schools.	Community home-like settings with multiple staff. Children are placed in a SAFE Home for an average of thirty (30) days, up to a maximum of forty-five (45) days, in order to allow DCF and SAFE Home staff the opportunity to make appropriate permanency and service planning decisions, thus minimizing the possibility of future placement disruptions.	Serves children who are referred by DCF	<u>Children ages 3-12</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
DCF	Supportive Housing Program	Provides subsidized housing and intensive case management services to DCF families statewide for whom inadequate housing jeopardizes the safety, permanency and well being of their children. Intensive case management services are provided to assist individuals to develop and utilize a network of services in the following areas: economic (financial support, employment assistance), social (housing, transportation, family support, parenting education, child care) and health (medical/mental health care for adult and child, relapse prevention, and abuse issues). Housing is secured in conjunction with the family and DSS provides a Section VIII voucher.	Home Settings Statewide  The program serves families statewide through a network of contractors managed by The Connection, Inc. Case management services are funded through DCF.	Current Involvement with DCF	<u>NA</u>  <u>Capacity: 365 families</u>
DCF	Therapeutic Child Care	Therapeutic support staff provides interaction through a one-to-one relationship with a trained, supervised, caring adult mentor. Focus is on increasing self-esteem, habilitation, resiliency, the development and	Home and community settings statewide	DCF and Residential Care Provider. This service aids in facilitating the discharge of youth from a more restrictive setting (e.g., residential) or assist in maintaining youth in	<u>Youth, and adolescents ages 11-17</u>  <u>Capacity: 50 children per year</u>

State Agency	Long-Term Care Program	Services	Settings	Eligibility	Demographics July 1, 2004 – June 30, 2005
		improvement of social skills and peer relations, and promoting age appropriate behaviors in normative, non-clinical settings therapeutic mentoring provides guidance, advocacy and education to youth with complex behavioral health needs through the use of structured, home and community-based interactions and activities.		their community.	

### III. State Long-Term Care Program Expenditures in Connecticut – SFY 2005

State Agency	Long-Term Care Program	Total Expenditures	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Connecticut Home Care Program (CHCP)	\$188,072,702	\$35,316,598	152,756,104			
DSS	Personal Care Assistance Waiver	\$10,271,934		\$10,271,934			
DSS	Acquired Brain Injury Waiver (ABI)	\$23,323,256		\$23,323,256			
DSS	Katie Beckett Model Waiver	\$12,328		\$12,328			
DSS	Breakthrough to the Aging Note: Information updated for SFY 2006	\$60,000				\$60,000 (SSBG)	
DSS	Seniors Helping Seniors Note: Information updated for SFY 2006	\$43,167				\$43,167 (SSBG)	

State Agency	Long-Term Care Program	Total Expenditures	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	CHOICES Note: Information updated for SFY 2006	\$2,815,015	\$167,000		\$296,616	\$323,649 (DHHS/CMS) \$2,027,750 SPAP-grant final year	
DSS	MediSave Note: Information updated for SFY 2006	\$40,000				\$40,000	
DSS	Home Share Programs Note: Information updated for SFY 2006	\$99,356	\$99,356				
DSS	CT Partnership for LTC - Information & Education Program Note: Information updated for SFY 2006	\$11,000	\$11,000				
DSS	Statewide Respite Care Program (for persons with Alzheimer's or related dementia) Note: Information updated for SFY 2006	\$1,269,008	\$1,269,008				

State Agency	Long-Term Care Program	Total Expenditures	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DSS	Retired Senior and Volunteer Program  Note: Information updated for SFY 2006	\$89,568				\$89,568 (SSBG)	
DSS	Supportive Services (Title IIIB) and Health and Wellness (Title IIID) and Administration	\$5,941,469	\$507,783 State Match		\$5,433,686		
DSS	Elderly Nutrition Program (Title IIIC)	\$10,641,082	\$2,268,661		\$6,323,516	\$519,000 (SSBG) \$1,529,905 (NSIP)	
DSS	CT's National Family Caregiver Support Program (Title IIIE)	\$2,036,897			\$2,036,897		
DSS	Congregate Housing Services	\$460,316			\$107,452	\$60,797 (SSBG) \$292,067 (HUD)	
DSS	Senior Community Service Employment Program	\$953,812			\$953,812		

State Agency	Long-Term Care Program	Total Expenditures	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
	Note: Information updated for SFY 2006						
DSS	Medicare Legal and Education Assistance Project  Note: Information updated for SFY 2006	\$557,762	\$135,762			\$47,000 DHHS/CMS \$375 SPAP final grant year	
DSS	Elderly Health Screening Program  Note: Information updated for SFY 2006	\$407,882	\$407,882				
DMR	Home and Community Based Services Waiver	\$421,312,866		\$421,312,866			
DMR	Intermediate Care Facility for the Mentally Retarded (ICF/MR)	\$164,728,201		\$164,728,201			

<b>State Agency</b>	<b>Long-Term Care Program</b>	<b>Total Expenditures</b>	<b>State Expenditures</b>	<b>Medicaid Expenditures</b>	<b>OAA Title III Expenditures</b>	<b>Other Federal Expenditures</b>	<b>Other Expenditures</b>
DMHAS	Case management-Mental Health	\$24,612,613	\$22,679,758	\$54,848		\$1,278,585	\$599,422
DMHAS	Assertive Community Treatment (ACT)	\$19,320,519	\$18,941,162	\$43,574		\$229,361	\$106,422
DMHAS	MH Intensive Outpatient Services	\$9,689,796	\$1,541,721			\$64,875	\$8,083,199
DMHAS	MH Outpatient Therapy Services	\$40,586,246	\$29,492,351	\$1,960,462		\$493,341	\$8,640,093
DMHAS	MH Residential - Group Home	\$21,769,576	\$19,713,882	\$406,618			\$1,649,076
DMHAS	MH Residential - Supervised Housing	\$27,845,133	\$24,440,303	\$88,200		\$1,298,420	\$2,018,210
DMHAS	MH Residential - Supported Housing	\$29,092,063	\$21,923,126			\$6,451,338	\$717,599

<b>State Agency</b>	<b>Long-Term Care Program</b>	<b>Total Expenditures</b>	<b>State Expenditures</b>	<b>Medicaid Expenditures</b>	<b>OAA Title III Expenditures</b>	<b>Other Federal Expenditures</b>	<b>Other Expenditures</b>
DMHAS	Psychosocial Rehabilitation	\$14,270,409	\$12,831,463			\$1,438,946	
DMHAS	Crisis Stabilization Beds (respite)	\$5,277,266	\$3,742,996	\$102,213			\$1,432,058
DMHAS	Mobile Crisis Services	\$15,667,916	\$14,243,568			\$1,424,348	
DMHAS	Long-Term Psychiatric Hospitalization	\$86,113,572	\$83,946,652			\$1,111	\$2,165,808
DMHAS	Substance Abuse Residential - Long-Term Treatment	\$28,595,773	\$24,244,083	\$73,783		\$3,103,304	\$1,174,603
DMHAS	Substance Abuse Residential - Long-Term Care	\$1,152,803	\$801,409			\$351,394	
DMHAS	Substance Abuse Residential - Transitional/ Halfway House	\$844,031	\$363,926			\$268,504	\$211,601

State Agency	Long-Term Care Program	Total Expenditures	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DECD	Congregate Operating Subsidy Program	\$5,029,671	\$5,029,671				
DECD	Elderly Rental Registry and Counseling	\$569,333	\$569,333				
DECD	Elderly Rental Assistance Program	\$1,399,054	\$1,399,054				
DECD	Housing Assistance and Counseling	\$560,000	\$560,000				
DOT	Local Bus Services	\$110,400,000	\$74,000,000			\$1,100,000	\$2,300,000 (local) \$33,000,000 (passenger fares)
DOT	ADA Paratransit Van Services	\$18,300,000	\$15,500,000			\$490,000 (Sec 5307)	\$885,000 (local) \$1,404,000 (passenger fares)

State Agency	Long-Term Care Program	Total Expenditures	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DVA	Veterans' Health Care Services	\$15,987,645	\$4,979,797	\$10,610,942			\$396,906
DVA	Residential and Rehabilitative Services	\$1,616,825	\$ 1,397,317				\$219,508
DCF	Care Coordination	\$632,500	\$632,500				
DCF	Children with Complex Medical Needs	\$4,131,017	\$4,131,017				
DCF	Community Life Skills	\$221,508	\$221,508				
DCF	Community Emergency Services	\$7,482,028	\$7,482,028				
DCF	Connecticut Children's Place (CCP)	\$10,900,006	\$9,922,987			*Federal Expenditures not available at this time.	\$977,019
DCF	Crisis Stabilization Beds	\$10,323,853	\$10,323,853				
DCF	Emergency Shelters	\$6,497,040	\$6,497,040				
DCF	Extended Day Treatment	\$6,857,999	\$6,857,999				
DCF	Family Support Team	\$706,529	\$706,529				

State Agency	Long-Term Care Program	Total Expenditures	State Expenditures	Medicaid Expenditures	OAA Title III Expenditures	Other Federal Expenditures	Other Expenditures
DCF	Family Violence	\$1,906,756	\$1,906,756				
DCF	Foster Care	\$29,811,217	\$29,811,217				
DCF	Foster Care Supports	\$4,813,818	\$4,813,818				
DCF	Group Homes	\$4,813,818	\$4,813,818				
DCF	High Meadow	\$9,274,758	\$8,407,537			*Federal Expenditures not available at this time.	\$867,221
DCF	Independent Living	\$5,040,778	\$5,040,778				
DCF	Intensive Home Based Services – Functioning Family Therapy (FFT)	\$212,520	\$212,520				
DCF	Intensive Home Based Services:	\$5,006,092	\$5,006,092				
DCF	Lifelong Family Ties Project	\$400,000	\$400,000				
DCF	Outpatient Adolescent Substance Abuse Treatment	\$313,592	\$313,592				
DCF	Positive Youth Development	\$345,250	\$345,250				
DCF	Residential Care	\$88,403,225	\$88,403,225				

<b>State Agency</b>	<b>Long-Term Care Program</b>	<b>Total Expenditures</b>	<b>State Expenditures</b>	<b>Medicaid Expenditures</b>	<b>OAA Title III Expenditures</b>	<b>Other Federal Expenditures</b>	<b>Other Expenditures</b>
DCF	Respite Care Services	\$104,337	\$104,337				
DCF	Riverview Psychiatric Hospital	\$27,161,610	\$24,031,547			*Federal Expenditures not available at this time.	\$3,130,063
DCF	Safe Homes	\$14,374,405	\$14,374,405				
DCF	Supportive Housing Program	\$4,242,814	\$3,551,311			\$691,503	
DCF	Therapeutic Child Care	\$1,385,256	\$1,385,256				