

Aging & Disability Resource Center National Meeting November 2005

State of Vermont
Department of Disabilities, Aging and
Independent Living
Patrick Flood, Commissioner

Posted 7/11/05

What do these People have in Common?

- 82 year old woman with Alzheimer's
- 43 year old quadriplegic
- 18 year old with TBI
- 27 year old with developmental disability

- They all want to live in their own homes, in their community, with their friends and families, surrounded by their own things.
- They want to be treated with dignity, and as much as possible, direct how they get the care they need.
- They need housing, income, health care, transportation, personal care, supervision, and help navigating the system.
- In short, they have much more in common than they have differences.

Over the years, our system has evolved to foster this change.

The Department of Aging and Disabilities was created in 1988 – include OAA, licensing, Waivers, Vocational Rehabilitation, blind services, other community services. Adult Protective Services was added in 1990.

1996 – Act 160 passed, requiring shift of Medicaid funds from nursing homes to home based care.

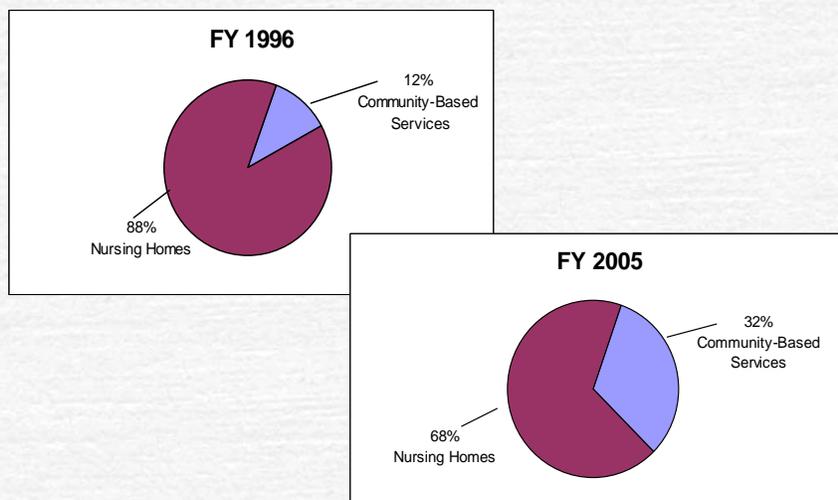
2004 – Re-organization of Human Services: DA&D became DAIL – Department of Disabilities, Aging and Independent Living. Includes Developmental Services, some disabled children's services.

2005 – Long Term Care 1115 Waiver

Vermont has been moving towards a system that:

- Supports people of all ages and disabilities living as independently as possible.
- Only 1 six-bed ICF-MR left; State's major ICF-MR closed in 1994.
- No longer have any institution for disabled children.
- Nursing Home use is down 18% since 1996.

Public Expenditures for Long Term Care



We are not completely there yet.

Example: 4 different Waivers, all with different services, eligibility and payments

We still have silos – re-organized into a major division

Makes a huge difference having all the services and programs in one department.

Policy changes can move faster.

Can achieve more consistency and equity.

What does this have to do with ADRC's?

We have achieved a lot without a single point of entry, but as the community system grows, change is needed.

We have relied on an "any door" approach.

This has worked pretty well over the years, but as the system expands, time for change.

We hear that consumers still don't know where to go for information.

There is no one place to get answers.

Consumers say, in some cases, they cannot get unbiased information.

We plan on changing that:

Year 1

- Improve I & A for older Vermonters
- Plan to pilot ADRC's
- Design seamless and streamlined Medicaid eligibility process

Year 2

- Add younger persons with physical disabilities and TBI
- Implement the streamlined Medicaid Eligibility
- Market ADRC to private pay individuals

Year 3

- Add persons with developmental disabilities

We believe this will result in:

- Informed choice of LTC options for all
- Streamlined access and eligibility
- Easier access to services
- Sustainable ADRC model that can be expanded statewide

This change is intertwined with other important initiatives.

- QA/QI across Waivers
- Cash and Counseling
- Systems Change Grant – Integration of Health and Long Term Care

The Questions:

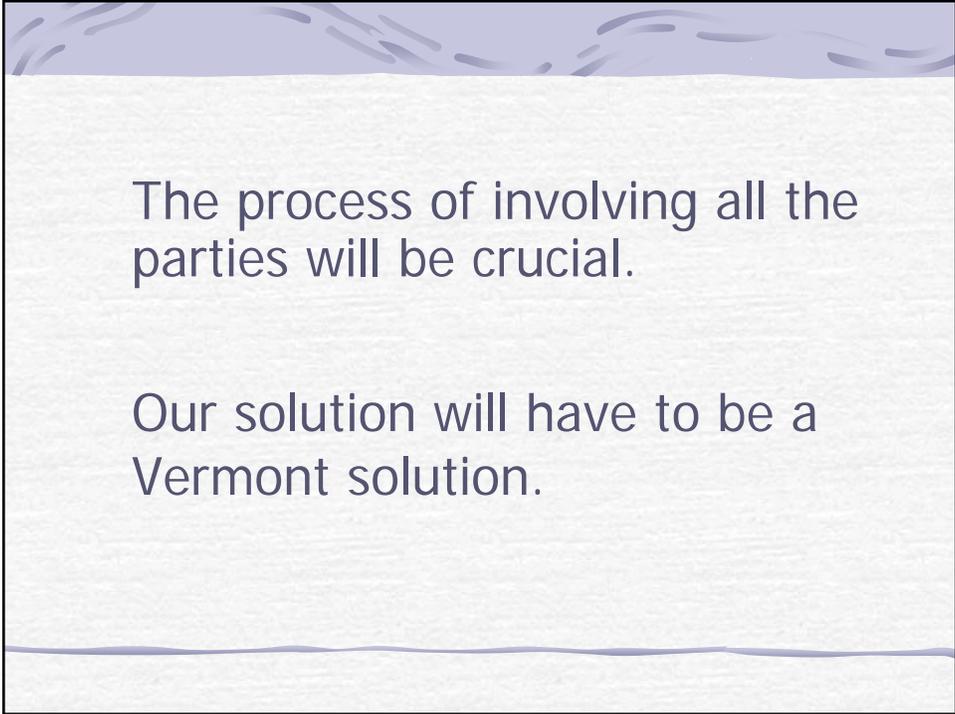
I&A is the easy part: technology, cross training, co-location

What about Medicaid eligibility, now a state function?

Cash and Counseling – who manages the money?

What about eligibility for other programs?

How will this work in a capitated system?



The process of involving all the parties will be crucial.

Our solution will have to be a Vermont solution.