



Compendium of the Systems Change Grants for Community Living



March 2002

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850



Center for Medicaid and State Operations
Disabled and Elderly Health Programs Group (DEHPG)

March 2002

Dear Reader:

In 2001, CMS awarded approximately \$70 million in Systems Change Grants for Community Living to 37 States and 1 Territory. We have prepared this Compendium of the Systems Change Grants for Community Living to be a user-friendly reference tool for our Systems Change Grantees, and others interested in these grants.

The Compendium will help you learn more about how these grants will be used to allow more people of all ages with a disability or long term illness to live and participate in their communities. We hope that Systems Change Grantees will also find it useful to identify other Grantees with similar goals and activities. A web-based edition of the Compendium will be made available on the CMS website at <http://www.hcfa.gov/medicaid/systemschange/default.htm> as well as on the Home and Community Based Resource Network (HCBRN) website at <http://www.hcbs.org>.

The Compendium contains basic information about each of the Systems Change Grantees. It is divided into different sections corresponding to the different types of grants: Community-Integrated Personal Assistance and Supports grants, Nursing Facility Transitions – State Program grants and Nursing Facility Transitions Independent Living Partnership grants, and Real Choice Systems Change grants. Each section is alphabetical by state. Information for each state includes: the name of the grantee organization, the title of the grant, the type of grant, the amount of the grant awarded and fiscal year awarded, the primary contacts for each grant, the target populations to be served under the grant, the primary goals and activities of each grant project, and a brief description of the grant activities.

In the coming months we expect to be adding information to the web edition of the Compendium regarding Systems Change Grants that will be awarded in FY 2002. With the assistance of our contractor, RTI, we will also be preparing additional reports that will provide more comprehensive descriptions of the Grantees' goals and activities.

Sincerely,

Thomas E. Hamilton
Director, Disabled and Elderly Health Programs Group

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ALASKA

Grant Information

<i>Name of Grantee</i>	Department of Administration, Division of Senior Services
<i>Title of Grant</i>	Alaska's Personal Assistance Services and Supports Project
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$900,000

Contact Information

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Anchorage, AK 99503

Subcontractor(s)

None at this time.

Target Population(s)

Individuals with disabilities or long-term illnesses, provider agencies, and other key stakeholders.

Goals

- Improve personal assistance services that are consumer-directed or controlled.
- Develop statewide training standards and competency testing for personal assistants working in agency-based programs.
- Increase training opportunities for personal assistants.
- Provide technical assistance to provider agencies, which advances the concept of individual dignity, choice, and consumer input and control.
- Provide opportunities for consumer feedback to provider agencies and the Division of Senior Services.

Activities

- Determine standards, develop competency test and testing process, and develop curricula for statewide training and testing.
- Identify technical assistance needs and a plan for providing technical assistance either directly or through a contractor.
- Develop RFP for regional training contracts.
- Assist consumer-directed PCA agencies in developing training manuals.
- Develop standardized consumer feedback form for all provider agencies.
- Conduct statewide consumer satisfaction survey.

Abstract

Alaska's Personal Assistance Services and Supports (PASS) project will be used to improve personal assistance services that are consumer-directed or controlled. The project will build upon existing and planned changes to Alaska's personal assistance programs, administered by the Division of Senior Services (DSS). The consumer-directed program (CDPAS), which provides consumers with the option to hire, train, and supervise their personal assistants, with the support of a fiscal intermediary agency, was implemented in October of 2001. Changes are also being proposed to the agency-based program, which will result in greater consumer choice and availability of services. These changes are scheduled for implementation in 2002.

Project funds will be used to develop training programs and provide technical assistance to provider agencies to improve consumer control and input for those individuals receiving agency-based services. Training will also be made available to individuals with disabilities or long-term illnesses and other key stakeholders to advance the concepts of individual choice and consumer control. Funds will also be used to implement strategies to increase the recruitment and retention of personal assistants.

ARKANSAS

Grant Information

<i>Name of Grantee</i>	Department of Human Services Division of Developmental Disabilities (DDS)
<i>Title of Grant</i>	DDS Pass Grant
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$900,000

Contact Information

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Little Rock, AR 72203-1437

Subcontractor(s)

Partners for Inclusive Communities (formerly UAP) Karan Burnette 501-682-9000
Other subcontractors to be determined by RFP process during first year of grant.

Target Population(s)

Individuals who meet the definition of developmental disabilities as defined by Arkansas state statute.

Goals

- Enhance consumer self-advocacy.
- Improve quality of life for individuals receiving services through the developmental disabilities system, in area of direct care staff.
- Explore new options for service delivery that embrace the concepts of self-determination and consumer choice and control.

Activities

- Develop a DDS advisory council composed of consumers and families to provide guidance as Arkansas seeks to incorporate best practices into the service delivery system.
- Enhance the self-advocacy network by empowering consumers and advocates with information from a web site and handbook.
- Develop an advertising campaign and materials for recruiting direct support professionals to provide community-based services.
- Commission a study and develop new service delivery options to include a one-stop shopping model inclusive of fiscal intermediaries and community boards.

Abstract

The Division of Developmental Disabilities Services through the PASS grant seeks to promote a change in the way services are provided to individuals with developmental disabilities. Our current model of cursory input as “consumer control” is no longer acceptable to many individuals who request and/or receive services through DDS. Concepts of independence, self-determination, and consumer control will be included as we move to design a more flexible and responsive system.

Through the PASS grant, DDS will develop an advisory council, train and support self-advocacy networks, and create an interactive website and handbook. These accomplishments will create an environment that will empower individuals and families to advocate for changes to the system, from initial design to implementation. The development of new service delivery system options that expand consumer choice and control and enhance quality is also a goal of this grant.

GUAM

Grant Information

<i>Name of Grantee</i>	Department of Integrated Services for Individuals with Disabilities
<i>Title of Grant</i>	Inadanña para Tinilaika—Partners for Change
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$300,000

Contact Information

Victor Boria, Administrator Division of Support Services 1313 Central Avenue Tiyan, Guam 96913	671-475-4646/4629	support@ite.net
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Subcontractor(s)

Guma' Mami, Inc.	Monica Flores Limtiaco	671-477-1757/1505
Catholic Social Services	Cerila Rapadas	671-635-1410
Guam Center for Excellence in Developmental Disabilities Education, Research and Services	Heidi San Nicolas	671-735-2480/81

Service Coordinator to be decided.

Off-island consultant specializing in individualized budgeting to be decided.

Resource Developer to develop a Creative Funding Task Force to be decided.

Target Population(s)

Ten individuals with developmental disabilities in need of personal assistance services who will participate in a 6-month pilot project. These individuals may include individuals who currently reside in group home settings, individuals who are inappropriately placed in institutions, and individuals who have minimal support systems.

Goals

- Develop and implement an individualized budgeting program that incorporates the development of an infrastructure representative of the needs and choices of persons with disabilities and their families.
- Develop a database infrastructure to create a system to track individual budgets and expenses under consumer-directed systems, and to conduct ongoing needs assessments of the number of persons with disabilities in need of personal assistance services.

- Promote and facilitate strong cross-program/natural support partnerships to optimize funding sources, and identify other creative funding mechanisms for the individualized budgeting program.

Activities

- Pilot and implement the individualized budgeting program.
- Develop an emergency response system for the individualized budgeting program.
- Develop consumer-directed quality assurance/personal outcomes measures that promote consumer and family involvement.
- Develop a Creative Funding Task Force to identify and research various funding alternatives and a mechanism for developing a comprehensive consumer-directed service delivery system.

Abstract

Guam's citizens with significant disabilities are in compelling need of personal assistance services. Although personal assistance is the most frequently used long-term care service throughout the United States, there are no personal assistance services available on Guam to enable persons with disabilities to live integrated and meaningful lives in the community. Due to the lack of personal assistance services, persons with disabilities are inappropriately placed in treatment facilities, continue to remain in congregate settings, and experience prolonged waiting periods for housing and supportive services. This problem is also aggravated because Guam is ineligible for funding under SSI and there is a cap on federal expenditures for Guam's Medicaid program.

Established in 1997, the Department of Integrated Services for Individuals with Disabilities (DISID) has experienced a rapid influx of persons with disabilities in need of supportive services. With a shortage of funding levels coupled with program overloads, there has been little or no hope for assistance or funding to develop an infrastructure to expand much-needed services.

DISID in partnership with two housing support providers, Guma' Mami and Catholic Social Services, proposes to create a model demonstration individualized budgeting program entitled: *Inadanña para Tinilaika—Partners for Change* for individuals with disabilities who require supports to live in the most integrated community setting to meet their needs and preferences. This pilot project will develop Guam's individualized budgeting infrastructure for persons with significant disabilities; implement an individualized budgeting pilot program; enhance interagency and natural support partnerships by sustaining a network of valuable supports, and develop consumer-directed quality assurance/personal outcomes measures that promote consumer/family involvement, to name a few activities.

MICHIGAN

Grant Information

<i>Name of Grantee</i>	Department of Community Health, Long Term Care Initiative
<i>Title of Grant</i>	Community-Integrated PASS Grant
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$755,972

Contact Information

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Subcontractor(s)

Developmental Disabilities Institute Wayne State University	Sharon Milberger, Sc.D. smilberg@math.wayne.edu	313-577-2654
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Target Population(s)

All Michigan residents who receive Medicaid funded personal assistance services.

Goals

- Optimize community integration and quality of life for children and adults by offering maximum consumer control of personal assistance and supports in all programs.

Activities

- Complete a service delivery system analysis.
- Forecast utilization possibilities and conduct cost analysis to support budget neutrality.
- Establish comparable assessment tools and care planning protocols across programs.
- Provide training and technical support for consumers and providers.
- Develop coordinated information systems.
- Integrate changes into ongoing programs for sustainability.

Abstract

Although in recent years Michigan has improved the quality of and expanded publicly funded personal assistance services and supports (PASS), the service system for people with functional limitations will have to undergo infrastructure reform if it is to meet future challenges. Presently in Michigan, five discrete programs offer PASS and serve over 73,000 children and adults. Each program was developed at different points in time in response to different needs and has its own eligibility criteria, care planning protocols, assessment tools, information system, and varying degrees of consumer control.

This 3-year project builds on existing system strengths to achieve radical systems change that will optimize community integration and quality of life for children and adults by offering maximum consumer control of PASS in all programs. Project activities include a service delivery system analysis to clearly identify system-level needs that involve all stakeholders, including consumers and families; a cost analysis to identify possible changes while maintaining cost neutrality; training and technical assistance to consumers, personal assistants, caregivers, and agency staff; developing comparable care planning protocols and assessment tools; coordinating information systems; supporting a sustainable long-term care workforce; and establishing feedback mechanisms for quality assurance for PASS in all programs.

A consumer task force will ensure consumer involvement in the implementation of all project activities. In addition to the integration of systems changes into on-going program development, sustainability summits involving all stakeholders will convene in Years 2 and 3 to develop a plan to ensure that each project activity is sustained beyond the grant period. Evaluation strategies using an empowerment evaluation model will be implemented throughout the project to ensure that formative and summative data results will inform ongoing project activities.

MINNESOTA

Grant Information

<i>Name of Grantee</i>	Department of Human Services Continuing Care for Persons with Disabilities
<i>Title of Grant</i>	Pathways to Choice: Minnesota's Consumer Directed Personal Assistance Program
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$900,000

Contact Information

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444 Lafayette Road Saint Paul, MN 55155-3872		

Subcontractor(s)

To be determined by an RFP process in the first year of the grant.

Target Population(s)

Consumers of all ages with all types of disabilities, especially communities of color.

Goals

- Increase the use of consumer-directed options for PCA services.
- Increase the availability of personal care workers.

Activities

- Develop consumer-initiated partnership and support networks to increase options for consumer-directed services.
- Develop programs to teach consumers fiscal skills to achieve savings that can be used to pay higher salaries for personal assistance workers.
- Develop consumer-tested training materials that can be shared on the Internet.

Abstract

For people of all ages with disabilities or long-term illnesses, Minnesota has developed a community-based system of comprehensive services with an array of options to move or keep people out of institutions. In its Medicaid plan and waiver services, the state offers personal assistance services or personal care assistance (PCA) services, with options giving consumers greater control over their service. However, very few consumers currently use these consumer-directed PCA options. In addition, as consumers note, service availability means little if there are no PCA workers available to get them out of bed in the morning. With one of the nation's tightest labor markets, Minnesota has a chronic worker shortage, keeping consumers from receiving needed services.

Minnesota seeks to both increase consumer direction and control of PCA services and address the worker shortage problem through the development of a consumer-initiated partnership and support networks (CIPS) model. Through CIPS, consumers will access each other's natural supports, such as family and neighbors, to provide PCA services, as well as to create back-up options. Networks will offer members opportunities for cooperative training, support, respite, service management, and group insurance policies.

CIPS members will be trained on how to increase control over the PCA process, including training in consumer-direction practices that can reduce administrative costs by teaching consumers how to be fiscal agents. The savings achieved will be used to offer higher salaries for PCAs, which will attract more workers. By using CIPS members as an interactive test group, the state will develop training materials that more effectively promote consumer-directed options among all service consumers.

The state will recruit organizations to sponsor networks. Inclusion of people of color, of tribes, and with severe disabilities will be a consideration in sponsor selection. Networks will become self-sustaining by serving as consumer-run fiscal agents, with funding by consumers who direct their case management dollars to the networks.

MONTANA

Grant Information

<i>Name of Grantee</i>	Department of Public and Human Services Senior & Long Term Care Division
<i>Title of Grant</i>	Montana CHOICE
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$850,000

Contact Information

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Subcontractor(s)

Spectrum Medical	Rick Bourne	800-870-9322
	Terry Preite	800-870-9322
Area II Agency on Aging	Karen Erdie	406-323-1320
Area X Agency on Aging	Evelyn Havskjold	406-265-5464

Public Relations subcontractor to be determined.

Target Population(s)

Consumers of all ages and disabilities.

Goals

- Alleviate competition for attendant-level personnel and ensure a consistent training process.
- Tap into previously underutilized resources such as older workers.
- Better community education and understanding of the need for quality personal care assistance.

Activities

- Develop a central mechanism for recruiting, screening, and training attendants to work across the home care continuum.
- Recruit, train, and place older workers as personal care attendants.
- Develop a statewide web site with training modules for individuals wishing to perfect attendant management skills through distance learning and on a consistent basis.
- Develop a public relations campaign to better educate the community to service needs and attendant abilities and challenges in providing this service.
- Develop caregiver support groups.

Abstract

Montana CHOICE is based upon and stands for Consumers Having Options in Community Environments. The grant project comprises a series of activities that will lead Montana's consumers and providers to understand, emulate, and promote integrated community living through the use of personal assistance services. We focus on three key areas: education, workforce, and services. Each area has specific projects that are interrelated to one another.

The grant's purpose is to change the average person's view of home-based long-term care and to provide participants (consumers, providers, or family members) with the knowledge base to participate fully in personal assistance services. Montana will manage a public relations campaign and a training program to meet this goal.

Montana CHOICE proposes two specific projects to address workforce issues. First, in collaboration with two Area Agencies on Aging, we seek to develop a program to attract older workers to the direct care pool. Second, our largest project is to create and blueprint ACCESS (Attendant Center for Communication, Education and Support Services). This central point for recruitment, training, education, and support will enable collaboration in addressing the workforce issue. Instead of competing for attendants, service organizations will participate in focused efforts to improve the system as a whole.

During our planning process, focus groups indicated the need to evaluate, enhance, and potentially modify the program. Evaluation will be through a consumer RESPOND group who will look at ALL issues relating to personal assistance service and make the tough administrative recommendations normally reserved for state personnel. Enhancement will come through caregiver support groups, continuation of focus groups, and a web based attendant management program. Together these groups will create or suggest modifications to the program to help make it work for all parties involved.

Consumers, advocates, family members, and providers of long-term care services will all participate in Montana CHOICE. Summit Independent Living Center will be the technical advisor on all projects to ensure we work towards community integration. The continuation of consumer focus groups will allow the state to receive honest input regarding grant activities, evaluations, and quality throughout the grant period. An integrated oversight committee will monitor overall grant activities.

NEVADA

Grant Information

<i>Name of Grantee</i>	Department of Employment, Training & Rehabilitation Office of Community Based Services
<i>Title of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$655,988

Contact Information

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Subcontractor(s)

University of Nevada Las Vegas	Dr. Tom Pierce Kyle Konald	702-895-1104 702-895-2915
Southern Nevada CIL	Mary Evilsizer	702-889-4216
Northern Nevada CIL	Joe Bohl	775-353-3599
Washoe Association for Retarded Citizens	Mary Bruan	775-333-8259

Target Population(s)

People with disabilities in need of or at risk of needing personal assistance services (PAS).

Goals

- Create a statewide network of cross-population PAS that will ensure access to PAS regardless of age, ethnicity, income, disability, or geographic location.
- Design, implement, and evaluate facilitating practices that ensure consumers are fully informed and able to select and direct their own services and care from a variety of models including a budget and service responsibility model.
- Demonstrate and document the efficacy of PAS services in providing access to available assistive technology and other independent living services as an integral part of service planning.
- Demonstrate and document the efficacy of training and employing adults with mental retardation as personal assistants through a supported employment prototype.

Activities

- Assess proposed interdisciplinary strategies from the consumer perspective and provide a consumer-directed basis for such strategies; develop strategies and structures for ensuring consistent consumer involvement in systems and policy development and in developing and evaluating PAS delivery options, training, and services; and ensure continuing feedback to consumers regarding all activities undertaken through this grant.
- Recommend and coordinate interdisciplinary action to remove and/or ameliorate barriers to consumer-preferred PAS models caused by policy, regulation, operational procedure, impeding practices, and deficiencies in the training provided to agency and/or provider personnel.
- Design, develop, and coordinate implementation of preferred service modes.
- Establish a consumer-directed State Governor's Council on Assistance Services to assess quality assurance issues and recommend legislation, policy development, and systemic change related to the provision of PAS in Nevada.
- Create a PAS web site for consumers of services that offer tips on service management, resource and service access information, announcements of meetings/events/opportunities for participation, "Topics of the Month," links to benefits counseling, and disability-related information.
- Train and provide supported employment opportunities for the high-functioning developmental disabilities population in provision of PAS services.
- Provide, through the Centers for Independent Living, peer evaluation of the perceptions, satisfaction, and issues of consumers of PAS services in all the state's programs.

Abstract

Through the efforts of Nevadans with disabilities, the 2001 Legislature mandated that all Nevadans requiring assistance with bathing, toileting, and eating must be identified and that planning for their needs must begin. The law also established a consumer-directed Personal Assistance Council to guide the state's efforts in providing access, consumer choice and control, training, and systems change related to all PAS.

The project is a collaboration of the PAS Council, State Aging Services, Medicaid, Family Health Services and Community Based Services Agencies, Nevada Universities, the Nevada Community Enrichment Center, the Council and Centers for Independent Living, and the Associations for Retarded Citizens.

NEW HAMPSHIRE

Grant Information

<i>Name of Grantee</i>	Granite State Independent Living
<i>Title of Grant</i>	ACCESS Consumer Controlled and Empowered Support
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$900,000

Contact Information

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Concord, NH 03302-7268		

Subcontractor(s)

Franklin Pierce Law Center	David Frydman	603-228-1541
Institute for Health, Law & Ethics		
EP&P Consulting, Inc.	Susan Flanagan	202-628-1134

Target Population(s)

Consumers on the state's Elderly and Chronically Ill Medicaid Waiver, and children with special health care needs and their families.

Goals

- Create comprehensive cross-disability and cross-age-group access to consumer-directed personal care.
- Increase the availability of personal care workers.
- Increase retention of personal care workers.
- Identify and address gaps in community services.

Activities

- Develop a model consumer-directed personal care service provider program (“PCSP”) that expands consumer-directed personal care to individuals who have not had access to such services.
- Implement a model consumer-directed PCSP program, which includes outreach and training to populations who have been previously denied access to such a program.
- Expand the availability of consumer-directed PCSP by providing education, outreach, and technical assistance to community-based entities that support a variety of different constituencies of individuals with disabilities throughout the state.
- Develop and implement back-up personal care coverage models.
- Make available mechanisms to better support the consumer-directed personal care workforce and thereby increase retention of personal care workers.
- Conduct a community Services Gap Analysis, identifying deficiencies, and work to expand the opportunities for individuals to live in the community and to have real choices regarding the services they want and need.

Abstract

The central goal of this project is to create comprehensive cross-disability and cross-age-group access to consumer-directed personal care. The project will expand consumer-directed personal care to large groups of people with disabilities in New Hampshire who have historically been denied access to such services.

New categories of eligible consumers will include people on the state’s Elderly and Chronically Ill Medicaid Waiver, and children with special health care needs and their families. Additionally, the project will expand the availability of direct care workers and backup coverage for all consumer-directed personal care programs.

The project will also work with consumers to identify and implement improvements to the entire community support system to provide more choices and control over service options.

OKLAHOMA

Grant Information

<i>Name of Grantee</i>	Oklahoma Department of Human Services Aging Services Division
<i>Title of Grant</i>	Oklahoma's CD-PASS Project
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$850,000

Contact Information

Carey Garland Deputy Division Administrator 312 NE 28 th , Room 101 Oklahoma City, OK 73105	405-522-4509	carey.garland@okdhs.org
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Subcontractor(s)

Long Term Care Authority of Tulsa	Michael Lester	918-879-5223
Ability Resources	Carla Lawson	918-592-1235
Progressive Independence	Jeff Hughes	405-321-3203

Target Population(s)

Aged, blind, and disabled persons with developmental disabilities.

Goals

- Create infrastructure that supports the availability of personal assistance services in a manner that affords consumers maximum control over the selection of individuals working on their behalf and the manner in which services are provided.
- Develop ILC-based Intermediary Services Organizations (ISOs) to serve as consumers' business agent and consultant for employer responsibilities.

Activities

- Guide the creation of CD-PASS infrastructure and develop an Intermediary Service Organization (ISO) implementation plan.
- Produce recommendations for Continuous Quality Improvement (CQI) contracting requirements as conditions of Provider Participation for CD-PASS Intermediary Services Organizations (ISOs).
- Develop CD-PASS infrastructure, implement CQI CD-PASS ISO contracting Conditions of Provider Participation and CD-PASS ISO startup operations providing consumers CD-PASS.
- Launch a second CD-PASS ISO.
- Evaluate and recommend modifications to the Nurse Practice Act provisions for delegation of nursing tasks to nonlicensed persons.
- Produce a comprehensive evaluation of all grant infrastructure development activities.

Abstract

DHS/ASD and DHS/DDSD are the Oklahoma state agencies responsible for administering Oklahoma's 1915(c) waiver programs. The LTCA of Tulsa is a local public trust authority that is the Administrative Agent for the ADvantage Program, the statewide waiver that serves 10,000 frail elderly and adults with physical disabilities. Ability Resources is an Independent Living Center (ILC) that has been a case management provider in the ADvantage Program since 1995. These entities are partnering to provide leadership to achieve the goals and objectives of this Project, which will focus on four major areas.

Consumer/community valued service delivery system. The Project will promote accountability of the service delivery system to consumers, providers, and policy makers through development of infrastructure modifications that afford consumer/community control in the design, implementation, and quality monitoring of PAS and CD-PASS service delivery.

Consumer-directed personal assistance services. The Project will create an infrastructure that supports the availability of personal assistance services in a manner that affords consumers maximum control over the selection of individuals working on their behalf and the manner in which services are provided. Infrastructure includes development of the ILC-based ISOs to serve as consumers' business agent and consultant for employer responsibilities.

Available, reliable, appropriate, and quality CD-PASS. The Project will produce a service delivery infrastructure that supports a CQI system that accords premium value for ISO provider and program evaluation and improvement of CD-PASS service delivery.

Flexible, accountable delegation of nursing tasks. The Project will recommend Nurse Practice Act language that supports appropriate delegation of nursing tasks to unlicensed staff or to family or friends who have received training from, and demonstrated skill attainment to, a registered nurse.

RHODE ISLAND

Grant Information

<i>Name of Grantee</i>	Department of Human Services
<i>Title of Grant</i>	Rhode Island's Community-Integrated Personal Assistance Services and Supports
<i>Type of Grant</i>	Community-Integrated Personal Assistance Services and Supports
<i>Amount of Grant FY 2001</i>	\$539,730

Contact Information

Deborah Florio, Chief Family Health Systems 600 New London Avenue Cranston, RI 02920	401-462-0140	dflorio@gw.dhs.state.ri.us
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Subcontractor(s)

Affiliated Consumer Systems/Birch and Davis <i>RFP issued for PASS grant activities (7/1/02-9/30/04).</i>	Rick Jacobsen, PhD.	401-462-6357
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Target Population(s)

Medicaid-eligible children with special health care needs.

Goals

- Design and implement a consumer-directed Personal Assistance Services and Support (PASS) program that will maximize control and choice for children with special health care needs and their families, potentially substitute for other therapeutic services in high demand, expand the pool of current service providers, and improve the continuum of services for children.
- Provide PASS support to children with special health care needs to enhance their independence and ability to live and participate in the community.

Activities

- Collaborate with consumers, advocates, and providers to guide the key design components of PASS.
- Develop certification and performance standards for PASS providers.
- Integrate PASS services into the existing Rhode Island Medicaid infrastructure CEDARR (Comprehensive Evaluation, Diagnosis, Referral, and Reevaluation services and supports) for children with special health care needs.
- Develop and implement specialized training modules targeted to key parties in the PASS program (consumers, broker agencies/fiscal intermediaries, PASS direct workers, CEDARR Family Centers).
- Implement a quality assurance and PASS program evaluation system that is data driven.

Abstract

The Rhode Island Department of Human Services (DHS) will establish two new services to expand consumer choice and maximize consumer control. These will be consumer-directed PASS for children and families using the Service Responsibility model and the Service Choice model. Services will be available to children and families with all types of disabilities. Presently the state plan does not include PASS for children outside residential facilities, and waiver-based PASS are overwhelmingly geared to adults. Currently, within the children's system, children and families often endure long waiting lists and inconsistent service provision.

These PASS services will fill a large void in Rhode Island. By the end of the grant period approximately 350 to 400 families will access Community PASS services. Funded as service benefits under EPSDT rules, the services developed through this grant will continue to be supported beyond the period of this grant.

This grant is particularly timely. Over the past 3 years DHS has partnered with consumers, providers, and other state agencies to redesign the ways in which services are available to children with special health care needs (CSHCNs) and their families. The resulting CEDARR initiative provides the supporting infrastructure and method for implementing Community PASS services to maximize informed choice, consumer control, continuing support for families, and continuous quality improvement. CEDARR includes two delivery system components developed in phases. Phase 1 was the development of CEDARR Family Centers (CFCs), which provide family-directed coordinated services to help families understand and navigate the system of services for CSHCNs. The first statewide CFC opened in April 2001, the second in September 2001, and a third is due in the spring of 2002.

Phase 2 is the development of CEDARR-certified direct services to fill gaps in the existing system. Community PASS services will be developed as CEDARR direct services. In partnership with consumer-focused workgroups, specific service requirements and responsibilities will be delineated and certification standards will be written. Any entity that can demonstrate compliance with the standards will be certified as an eligible provider. DHS brings both an experienced team and a tested approach to the tasks of service design, implementation and startup, targeted training and technical assistance (for families, service worker brokers, direct service workers, and CEDARR Family Center staff), and quality assurance oversight and monitoring.

The CEDARR Policy Advisory Committee, an 11-member body that includes six family representatives (one as co-chair) and one member each from five state agencies, will ensure direct consumer involvement through all phases of this project.

ALABAMA

Grant Information

<i>Name of Grantee</i>	Mid-Alabama Chapter of the Alabama Coalition of Citizens with Disabilities, <i>DBA</i> Birmingham Independent Living Center
<i>Title of Grant</i>	Partnerships to Independence
<i>Type of Grant</i>	Nursing Facility Transitions, Independent Living Partnership
<i>Amount of Grant FY 2001</i>	\$1,025,000

Contact Information

Daniel Kessler
Birmingham Independent Living Center
206 13th Street S.
Birmingham, AL 35233-1317
www.birminghamilc.org

205-251-5403

dgkessle@bellsouth.net

Subcontractor(s)

No subcontractors planned.

Target Population(s)

People with disabilities who wish to transition from nursing homes to the community. The population includes residents of Jefferson, Shelby, St. Clair, Walker, and Blount Counties in Alabama.

Goals

- Increase nursing home residents' awareness of independent living options.
- Assist nursing home residents' transition to the community.
- Recruit, hire, and train qualified personnel who are committed to the philosophy of independent living and person-centered planning.
- Promote the development of resource networks through local and statewide implementation teams.

Activities

- Peer Outreach Advocates will be recruited, trained, and supervised to conduct outreach to nursing homes in the catchment areas.
- Develop a consumer-directed person-centered assessment model.
- Assist at least 25 individuals to transition from a nursing home to the community.
- Produce a manual that can be replicated by sites around the state, region, and country.
- To conduct local implementation team meetings monthly during the first year and quarterly during years 2 and 3.

Abstract

Birmingham Independent Living Center (BILC), in collaboration with its partners, proposes to expand services to persons with disabilities in Alabama with an Independent Living Partnership Nursing Facility Transitions program entitled **Partnerships to Independence**. The cost of nursing home care in the State of Alabama is spiraling out of control. By the end of 2001, nursing home costs will exceed \$600 million. At the same time, nursing home residents who desire to live in the community are given little opportunity to weigh community options. This project will develop the infrastructure, partnerships, and community services that will be required to offer the choice of community living to nursing home residents across the state.

The target population will include nursing home residents in the Birmingham service areas who express a desire to return to the community, regardless of age or disability. Contact with participants will be made at nursing homes. All potential participants will benefit from peer support, which means people with disabilities, older people, and family members who are familiar with the community will conduct outreach. A full-time Community Transitional Advocate will assist nursing home residents to plan their moves and obtain required supports. Plans will be developed according to independent living and person-centered principles. Community supports that will be put in place include personal assistance, housing, home modification, advocacy, peer support, transitional subsidies, and other resources. It is anticipated that 25 people will transition to the community during the 3-year project period.

Partnerships at the local and state level are a key to the success of this program. The Director of Alabama Medicaid's Long-Term Care Program will convene a group of statewide partners to advise on project direction and assist in the development of policy and sustainable resources for implementation. A local implementation team will be developed to enhance service planning and the development of local resources.

ALASKA

Grant Information

<i>Name of Grantee</i>	Department of Administration, Division of Senior Services
<i>Title of Grant</i>	Alaska's Nursing Facility Transitions Project
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$800,000

Contact Information

Gloria Masaric, Program Coordinator 907-269-3681 Gloria_Masaric@admin.state.ak.us
3601 C Street, Suite 310
Anchorage, AK 99503

Subcontractor(s)

None at this time.

Target Population(s)

Medicaid eligible individuals or those determined to be within six months of Medicaid eligibility who want to make the transition from a nursing facility to the community.

Goals

- Provide services to enable people to transition from nursing facilities to the community.
- Develop an enduring system to transition and divert people from nursing facilities to the community to the extent they desire.
- Evaluate project activities and outcomes and develop recommendations to further improve the transition/diversion program.

Activities

- Identify and develop partnerships to facilitate the nursing facility transition grant.
- Work with nursing facility staff to identify targeted individuals.
- Assess each individual's transition/community needs and, once placed in the community, monitor the individual's situation to determine if his or her needs are met, and arrange resources and supports as needed.
- Work in conjunction with existing housing initiatives, AHFC, and other housing resources to develop a variety of strategies to increase the availability of accessible, affordable housing stock.
- Work in conjunction with other initiatives and activities to increase the availability of services and supports that will support transitions and diversion (e.g., accessible and affordable transportation and front line workers).

Abstract

The main goal of the NFT project is to help identify individuals who want to make the transition from nursing facilities to the community, and to ensure there is a system in place to provide supports and services needed for the transitions or diversion.

The Division of Senior Services will manage the project and employ a project coordinator responsible for education, information dissemination, outreach, and coordination of the transition process. The project coordinator will also work with nursing facility staff to identify targeted individuals. Once individuals are identified, the project coordinator will assess each individual's transition/community needs, provide care counseling, and arrange for peer counseling if desired by the individual. The project coordinator will then convene a planning team to assist the consumer to determine needed services and resources.

In order to develop the infrastructure and programs to support the transition and ongoing support needs of participants, activities will be coordinated with Division of Senior Services staff. We are fortunate that the Rural Long Term Care Development staff members are located within the Division. These two staff persons are knowledgeable about housing efforts going on statewide and are a resource to staff.

Rural Long Term Care Development staff are part of a number of statewide committees looking at housing options. Feedback to the other organizations listed in the grant to partner and coordinate efforts will be a priority. The Division of Senior Services (DSS), as well as the other participating stakeholder organizations, such as the Governors' Council on Disabilities and Special Education, will be able to make policy recommendations to DSS, who in turn will work with the Department of Health and Social Services and, specifically, the Division of Medical Assistance (Medicaid single state agency), to develop a strategy for policy change, including how to fund and how to implement new policies and/or benefits.

COLORADO

Grant Information

<i>Name of Grantee</i>	Department of Health Care Policy and Financing Office of Medical Assistance
<i>Title of Grant</i>	Colorado Transitions Project
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$800,000

Contact Information

Dann Milne, Manager 1575 Sherman Street Denver, CO 80203-1702	303-866-5912	Dann.Milne@state.co.us
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Subcontractor(s)

Atlantis/ADAPT	Mike Auburger Autumn Gold	303-733-9324 303-715-3998
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Target Population(s)

Individuals of any age with disabilities in nursing facilities, particularly individuals with cognitive disabilities or mental illness.

Goals

- Build capacity across the state to reach out and support the transition of individuals in nursing facilities to a community integrated living arrangement.
- Assure that individuals who wish to make the transition have developmentally appropriate information to make the decision and the supports necessary to sustain long-term residence and participation in the community.

Activities

- Create a State Transitions Resource Team to oversee and evaluate the project.
- Identify barriers to transitions and strategies to address them.
- Document a comprehensive model for transitions.
- Establish ten support networks through Independent Living Centers to coordinate services, referrals, and follow-up.
- Inform over 1,200 individuals of their rights to live in the community.
- Transition at least 130 individuals in nursing facilities to community settings.

Abstract

The Colorado Transitions Project will create a state infrastructure for transition efforts and provide choice information to over 1,200 individuals in nursing facilities resulting in 130 transitions to the community. The approach will create a structure at the state level and in 10 communities to link resources, address barriers, and expand communication among providers to maximize the supports for community transitions.

The existing Olmstead Planning Group collaborated to design this proposal and will continue, with added members, as the State Resource Team. More partners will be added as the project expands and identifies additional key players.

A new product to be created through this project is a developmentally appropriate approach to informed consent for individuals with developmental disabilities, cognitive disabilities, brain injuries, language/literacy barriers, or mental illness, or who are affected by strokes. A video, a word board, and a picture book will be developed. These will reach individuals in a respectful manner and can be replicated in other states.

A Colorado Department of Health Care Policy and Financing State Transition Coordinator (0.5 FTE) will coordinate the state infrastructure development, and Atlantis/Adapt Independent Living Center will hire a Project Coordinator (1.0 FTE) to implement the Colorado Transitions Project through the network of 10 Independent Living Centers across the state. The project will complement existing state programs and identify and transition a variety of consumers from nursing facilities to the community.

CONNECTICUT

Grant Information

<i>Name of Grantee</i>	Department of Social Services, Health Care Financing
<i>Title of Grant</i>	Nursing Facility Transitions to Independent Living
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$800,000

Contact Information

David Parrella, Medicaid Director 25 Sigourney Street Hartford, CT 06106	860-424-5116	david.parrella@po.state.ct.us
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Subcontractor(s)

Connecticut Association of Centers for Independent Living, Inc. (CACIL)	Dawn Lambert	203-729-0153
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Target Population(s)

Nursing facility residents who want to return to independent community living.

Goals

- Identify and transition 150 nursing facility residents who want to return to independent community living.
- Develop an effective and sustainable community-based system of transition for individuals residing in nursing facilities who desire to live in the community and can be appropriately served in the community.
- Establish a strong partnership with Connecticut's Centers for Independent Living (CILs).

Activities

- Research, evaluate, and implement best practices in nursing facility transition.
- Design and implement an effective outreach campaign with materials that inform nursing facility residents and their families about long-term care alternatives.
- Design professional development and value-based training for targeted audiences that includes information about the needs of persons with disabilities, the principles of independent living, self-determination and social role valorization, and cultural diversity.
- Create a flexible financial resource that will facilitate the transition of nursing facility residents back to the community and give them increased self-direction and control.
- Develop and implement a volunteer peer support network that will provide technical assistance to persons transitioning to the community and their families, and provide the critical link to the informal community system.
- Develop an effective system to access affordable, accessible housing resources.
- Implement a demonstration project to transition 150 people out of nursing facilities.

Abstract

The Connecticut Association of Centers for Independent Living (CACIL) will be responsible for the overall management and administration of grant activities including the provision of financial support for project staff in the five Centers for Independent Living that will implement the project's activities.

This grant grew out of an awareness that there is a lack of training and education about the needs of persons with disabilities living in the community and that this has led to a long-term care system that is not responsive to the needs of consumers or their families. Connecticut does not have a system in place to identify nursing facility residents who are appropriate for transition to the community. Connecticut nursing facility residents do not have information about the choices available to them or a way to identify themselves as possible transition candidates. Systems fragmentation and the eligibility requirements of community-based programs leave many people unable to find adequate community support.

To address these issues, the grant will be used to develop a variety of products to better inform state agency staff, professionals in the community, and nursing facility residents about the concepts of independent living and self-direction. Best practices and policies will be identified and made available. A self-assessment tool and a "step-by-step" guide to community transition will be developed so that nursing facility residents and their families can assess their readiness for a successful transition. A professional assessment tool along with a procedures and marketing plan for distributing information to nursing facility residents will be developed. A Common Sense Fund will be established to help pay for items that are usually not covered by government programs, such as rental deposits, utility deposits, and household goods. All of these products will form the foundation of the system being designed to transition nursing home residents back to community living.

GEORGIA

Grant Information

<i>Name of Grantee</i>	disABILITY LINK
<i>Title of Grant</i>	“TRANSITIONS: Introducing Institutionalized People with Disabilities to Community Living Alternatives”
<i>Type of Grant</i>	Nursing Facility Transitions, Independent Living Partnership
<i>Amount of Grant FY 2001</i>	\$400,000

Contact Information

Rebecca Tuttle, Executive Director disABILITY LINK 755 Commerce Drive, Suite 415 Decatur, GA 30030 www.disabilitylink.org	404-687-8890	rrtuttle@disabilitylink.org
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Subcontractor(s)

Access Center for Independent Living	Robert McGarry	770-534-6656
Bainbridge Advocacy Individual Network	Virginia Harris	229-246-0150
Disability Connections	Jerilyn Leverett	478-743-9805
Living Independence for Everyone	Frances Todd	912-920-2414
Walton Options for Indep. Living	Tiffany Johnston	706-724-6262

Target Population(s)

Persons of all ages with disabilities who are currently residing in nursing homes.

Goals

- Develop a transition infrastructure within the Independent Living Network that will introduce people with disabilities to peer supporters and role models; expose interested persons to home and community-based services; offer information, training, and skill development; develop community connections or circles of support; and develop comprehensive transition plans to assist those who choose to resettle in the community.
- Develop a partnership with two nursing home chains to identify people with disabilities who want and need alternatives; and develop a collaborative process for both diverting people from nursing facility placement and transitioning those who want a community alternative.
- Work with the Department of Community Health to address current problems—from the consumer perspective—with the HCBS waivers.

Activities

- Subcontract with Centers for Independent Living (CILs) across the state to hire and train transition team leaders. These individuals, with the assistance of volunteer peer supporters, will go into nursing home facilities to identify individuals wishing to transition to the community.
- Work with the Department of Community Health and two nursing home chains to identify and transition people with disabilities to their communities.
- Expand existing community-based services to serve all those who wish to live in their communities.
- Expand and strengthen the Consumer Systems Change Network.
- Develop resource committees statewide.

Abstract

Georgia will use this grant to build state capacity to reach out and support the transition of individuals to a community-integrated living arrangement consistent with their needs and preferences, and assure that these individuals have the supports necessary to sustain long-term residence and participation in the community. A considerable amount of matching resources will also be allocated to this project.

DisABILITY LINK in Atlanta will serve as the fiscal agent for the grant, house the Project Director and contract with the six other consumer-controlled nonprofit CILs to accomplish the goals, objectives, and deliverables of this grant. The Statewide Independent Living Council (SILC) will serve as the project's steering committee, meet quarterly, provide guidance and support to the Project Director, and assist with the development of the grant process. The SILC is a statewide organization that is consumer-controlled and includes disability groups that are most at risk for institutionalization—people with cognitive disabilities, mental disabilities, and severe physical disabilities.

The project's goals will be accomplished by securing a Project Director, securing transition team leaders in seven regions of the state through the CILs, supporting the participation of consumers in transition planning, providing information and training to all consumers and staff, developing resource materials, and evaluating the project.

GEORGIA

Grant Information

<i>Name of Grantee</i>	Georgia Department of Community Health Division of Medical Assistance, Aging & Community Services
<i>Title of Grant</i>	Nursing Facility Transitions Grant
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$627,211

Contact Information

Bonnie Hurd, Program Specialist New Initiatives 2 Peachtree Street, NW, 37 th Floor Atlanta, GA 30303	404-463-8365	bhurd@dch.state.ga.us
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Subcontractor(s)

LH Kendall Consulting	Linda H. Kendall	828-259-9834
DisABILITY LINK	Rebecca Ramage-Tuttle	404-687-8890
Three Rivers Area Health Education Centers*	Jan Pittman	706-660-2499
Foothills Area Health Education Centers	Sheila Griffin	770-533-6866

Target Population(s)

Twenty-four Medicaid-eligible individuals residing in 18 rural and underserved counties in the state.

Goals

- Identify and implement policy changes needed to bring about improvements in the long-term care system.
- Build the capacity of providers of nursing home services in Georgia to offer community support services.
- Increase the number of individuals who transition from long-term care nursing facilities to appropriate community-integrated living arrangements.
- Increase the number of trained, reliable, and quality community service workers.

Activities

- Establish a Consumer/Provider Task Force to identify, prioritize, and develop strategies to overcome institutional bias in state policy.
- Conduct a comprehensive community resource mapping project and work force development project in 18 county pilot areas to identify barriers and opportunities for increased community services and direct care workers.
- Identify individuals who express an interest in community placement through a statewide survey.
- Work in partnership with Centers for Independent Living to relocate 24 nursing home residents to the community.

Abstract

The purpose of this project is to build state capacity to provide outreach and support the transition of people residing in nursing homes to a community-integrated living arrangement consistent with their needs and preferences and to assure that these individuals have the support necessary to sustain long-term residence and participation in the community. This will be accomplished through careful study and recommended changes to state policy, development of community services and the direct care workforce, and relocation of 24 individuals presently residing in nursing homes to the community. Grant activities will focus on a service area of 18 rural and primarily underserved counties.

We will accomplish the goals of this project through collaboration with a diverse workgroup consisting of consumers, advocates, state agencies, and providers, including two of the three largest providers of nursing home services in the State of Georgia. By demonstrating that providers of nursing home services can encourage community placement, this project will establish a lasting legacy and true systems change. In essence, the project seeks to demonstrate that effective systems change can be a “win-win” situation for both consumers and providers.

Grant staff will work in close partnership with disABILITY LINK, a Georgia Center for Independent Living, which was also awarded a nursing facility transitions grant. Working together will enable the two grant projects to have greater impact on building state capacity and support for community living.

INDIANA

Grant Information

<i>Name of Grantee</i>	Family and Social Services Administration
<i>Title of Grant</i>	Comprehensive Plan for Community Integration and Support of Persons with Disabilities
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$770,000

Contact Information

Alison Becker, Director of Fiscal Services 317-234-1527 abecker@fssa.state.in.us
P.O. Box 7083
Indianapolis, IN 46207-7083

Subcontractor(s)

A Request for Proposals has been sent out. The selection of contractors for consulting and evaluation work will be made within the next few months.

Target Population(s)

Individuals currently residing in nursing facilities and individuals who are at risk of entering a nursing facility.

Goals

- Develop and implement changes needed to the pre-admission screening process to determine individuals who could be successful in a community placement.
- Develop local coalitions for diversion and deinstitutionalization activities.
- Develop appropriate housing options.
- Develop a specialized case management system to aid in transition.
- Simplify eligibility for community services.

Activities

- Establish at least one local coalition.
- Make necessary changes to eligibility and pre-admission screening laws and regulations.
- Establish partnerships with hospital discharge planners.
- Make necessary amendments to Medicaid waivers.

Abstract

The grant focuses on transitioning nursing facility residents for reintegration into their communities. The project also targets individuals who are at risk of entering a nursing facility. The funds will be used to implement the following changes. Using the pre-admission screening process, Minimum Data Set assessment data and outreach, we will identify appropriate candidates for participation. The grant will help develop a system to identify individuals for the long term. By bringing the Family and Social Services Administration, Long-Term Care Ombudsman, Area Agencies on Aging, Independent Living Centers, consumers, advocates, assisted living facilities, and the nursing home industry together, we will address barriers to success at the local level.

The intent is to make changes that are needed, which vary from place to place, and to bring about the most noticeable changes in each area. Case management functions will be extended to include more immediate and frequent communication, as well as on-site monitoring and contacts with service providers. An evaluation will be completed on the efficacy of the coalitions and enhanced quality activities.

MARYLAND

Grant Information

<i>Name of Grantee</i>	Making Choices for Independent Living, Inc.
<i>Title of Grant</i>	Independent Living Partnership
<i>Type of Grant</i>	Nursing Facility Transitions, Independent Living Partnership
<i>Amount of Grant FY 2001</i>	\$450,000

Contact Information

Frank Pinter, Executive Director 5807 Harford Road Baltimore, MD 21214 www.mcil-md.org	410-444-1400	frankp@mcil-md.org
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Subcontractor(s)

Resources for Independence	Lori Magruder	301-784-1774
Center for L.I.F.E.	Gene Potts	301-884-4498
Eastern Shore CIL	Price Baum	410-221-7701
Independence Now, Inc.	Cathy Raggio	301-277-2839
The Freedom Center	Jamey George	301-846-7811

Target Population(s)

Persons with disabilities who live in nursing homes throughout the state who wish to explore the option to live independently in the community.

Goals

- Conduct outreach to nursing home residents who want to better understand their service options and who may want to relocate to the community.
- Educate and assist these individuals and their support systems to understand, identify, and procure local community resources.
- Compile and distribute resource materials from the local community using a first-person perspective.
- Empower individuals with disabilities to advocate for themselves.

Activities

- Provide outreach to nursing home residents, family members, support systems, significant others, and staff.
- Provide face-to-face peer counseling sessions with individuals who are interested in learning about community options.
- Provide accurate and useful information about community resources, including education about independent living centers and their philosophy of self-determination.
- Develop a peer counseling relationship for those who wish to discuss concerns and fears about transitioning.
- Work with existing state programs to ensure that the transitioning process is successful and consumer controlled.
- Develop a curriculum to empower individuals with disabilities to advocate for themselves.

Abstract

Making Choices for Independent Living, Inc. (MCIL), Maryland's oldest and largest center for independent living, proposes to work in partnership with Maryland's network of Centers for Independent Living (CILs) to conduct outreach and assistance to over 2,800 Medicaid beneficiaries currently residing in 231 nursing facilities across the state. Originally established in 1978, MCIL has an extensive and impressive history of assisting interested people to come out of nursing homes and return to the community. In 2000, MCIL was nationally recognized for its efforts.

This project, entitled the Independent Living Partnership (ILP), will be a unique and collaborative effort. It will partner with the other statewide CILs and State Medicaid Home and Community Based Services programs to supplement and improve existing services for the duration of the project and beyond. The results of the project could be replicated nationwide and will serve as a model for CILs in other states to use. In Maryland, the project will enable the rest of the CILs to gain valuable experience and expertise which can be used to expand on the grants' successes.

MARYLAND

Grant Information

<i>Name of Grantee</i>	Department of Human Resources (DHR) Office of Personal Assistance Services
<i>Title of Grant</i>	Nursing Facility Transitions Grant
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$800,000

Contact Information

Rhonda Workman, Director Office of Personal Assistance Services 311 West Saratoga Street Baltimore, MD 21201-3521	410-767-7479	rworkman@dhr.state.md.us
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Subcontractor(s)

Procurement of subcontractors is in process; therefore, information is not available at this time.

Target Population(s)

Individuals with physical disabilities, 65 years and younger, who are currently residing in nursing facilities and want to move into the community.

Goals

- Meet a minimum of 150 individuals' preferences and housing needs in a manner that allows for flexibility, choice, and self-direction,
- Provide better coordination of community housing and support services,
- Improve quality of transition services,
- Expand community housing alternatives,
- Develop policy, program, and regulatory changes to sustain the positive system changes,
- Develop measurable performance outcomes for monitoring, evaluation, and utilization review to promote effectiveness and efficiency.

Activities

- Educate and assist individuals and their support systems to understand, identify, and procure local community resources.
- Develop and sustain working relationships with public housing authorities and other housing resources in all Maryland jurisdictions.
- Systemically address the expansion and development of new housing resources.
- Compile and distribute listings of affordable, accessible housing resources and community support services.
- Provide grant funds not otherwise available for transitional costs associated with moving to the community.

Abstract

The Maryland Nursing Facility Transitions Grant is a statewide program designed to identify and expand affordable, appropriate, and safe housing for persons desiring to move from nursing facilities to the community, and assist with transition-related activities and costs including security deposits, utility hook-ups, furnishings, environmental modifications, procuring community based support services, etc. Federal funding will be used to develop a team, the **Home Team**, for coordination/collaboration with local housing authorities and housing providers, outreach workers, and case managers to assist in obtaining housing for a minimum of 150 Medicaid beneficiaries currently residing in 231 Maryland nursing facilities.

The following agencies will collaborate in this project: the Maryland Department of Housing and Community Development (DHCD), the Department of Health and Mental Hygiene (DHMH), the Department of Human Resources (DHR), the six Maryland Centers for Independent Living (CILs), the Coordinating Center, the Public Housing Authorities, and other housing providers. This interagency collaborative program will be administered through the Department of Human Resources, Office of Personal Assistance Services, which will also provide program coordination. The Department of Housing and Community Development will house and recruit a "Housing Coordinator" position; and the state will award contracts to the six CILs who will provide Housing Transition Services.

The Nursing Facility Transitions State Program Grant will be closely linked with Maryland's Independent Living Partnership Grant through coordinated outreach and peer counselors to target individuals with physical disabilities, 65 years and younger, who are living in nursing facilities and want to move into the community. To maximize collaboration and resources, the two programs will have one advisory committee, comprising individuals with disabilities and agency representatives. Through implementation of these programs, Maryland expects to develop an extensive peer outreach program, reach well over 2,000 people, and build community-housing capacity. Major gaps related to affordable accessible housing, lack of education pertaining to community resources, and funding needed to assure successful transitioning will be addressed and resolved.

Activities

- Establish interagency, interdisciplinary case management team to assist individuals transitioning to the community.
- Develop a coordinated housing strategy on a statewide basis and local strategies to secure accessible, affordable housing for individuals transitioning out of nursing facilities.
- Link person-centered advocacy and self-determination groups with individuals transitioning from or considering transitions from nursing facilities to community living to provide direct support through peer mentors and community connections facilitators.
- Educate the greater Worcester community to build community capacities to engage individuals transitioning from nursing facilities.
- Establish a local citizen advisory committee composed of at least 51% of individuals with disabilities and families that will promote the independence of individuals to transition out of nursing facilities, and provide direct advice to the project.

Abstract

The Massachusetts Department of Mental Retardation, with the cooperation and support of the Division of Medical Assistance, the Massachusetts Rehabilitation Commission, the Department of Public Health, the Executive Office of Health and Human Services, the Executive Office of Administration and Finance, and the Executive Office of Elder Affairs will use the grant to transition individuals with a significant disability from nursing facilities in the greater Worcester area to community living.

The 3-year project, known as the Massachusetts Bridges to Community Project, will examine the impact that three specific variables might have on the success of transitioning individuals out of nursing facilities and having them successfully remain in community settings. The three variables are: a dedicated interdisciplinary case management team approach; focused housing search along with expansion of housing options; and participation of individuals in the project management structure along with inclusion of peer mentoring, self advocacy organizations, and community education.

Year 1 of the project will include the following activities: establishing the project team; hiring the peer mentoring and self advocacy organizations; establishing the local citizen advisory committee and the interagency steering committee that will oversee policy direction; reviewing the Minimum Data Set in the state and other information to identify the individuals who will be targeted for this project; developing a working and collaborative relationship with the nursing home industry as well as local town and city officials, community service agencies, housing agencies, providers and developers, and faith-based organizations; and creating the methodology to evaluate the implementation of the project.

Years 2 and 3 will be focused on transitioning individuals out of nursing facilities, securing adequate and appropriate supports to assure success in the community, identifying community service gaps (including housing), and compiling data to evaluate project process and outcomes.

MICHIGAN

Grant Information

<i>Name of Grantee</i>	Department of Community Health, Long Term Care Initiative
<i>Title of Grant</i>	Nursing Facilities Transition Initiative
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$770,000

Contact Information

Virginia R. Harmon, Deputy Director 3423 N. Martin Luther King, Jr. Blvd. Lansing, MI 48909	517-335-9371	harmon@state.mi.us
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Subcontractor(s)

Corporation for Supportive Housing	Lisa Chapman	810-229-7712
University of Michigan Turner Geriatric Clinic	Katherine Supiano	734-764-2556

Target Population(s)

Persons who reside in nursing facilities who either no longer require nursing facility care or no longer wish to remain in a nursing facility; persons leaving hospitals who do not wish to enter a nursing facility or who require only a short-term nursing facility stay.

Goals

- Assure that the needs of persons who have traditionally resided in nursing facilities are included in the planning and development of housing projects.
- Develop a working model for preventing precipitous admissions to nursing facilities.
- Inform housing providers regarding supportive services that are available to help persons avoid premature nursing facility admission.
- Identify a model of access to services that are available outside of nursing facilities.
- Assure that persons who require only a short-term nursing facility stay are offered the opportunity to return to the community.
- Identify obstacles to funding services and to develop a uniform funding protocol across affected systems.

Activities

- Educate local community housing consortia regarding the needs of the nursing facility population to assure that those persons will be included in the consortia's planning.
- Use HUD's Project Access Section 8 housing subsidies to transition nursing facility residents to the community.
- Develop and provide education, training, and technical assistance on housing and services to persons and entities identified through the various components.
- Create a cross-systems policy framework that identifies obstacles and facilitates the transition from nursing facility care to community living.
- Link nursing facility diversion staff to transition component activities and to local resources to assist, thereby diverting nursing facility admissions or extended nursing facility stays.

Abstract

There are four basic components to the grant activity: transition, diversion, education, and evaluation. In addition, grant activities will be linked with activities of a state-funded housing initiative designed to promote the development of affordable, accessible housing.

Transition. Activities under the housing initiative are designed to educate housing consortia in communities regarding the needs of special populations and to assist in the development of strategies to meet the needs of individuals requiring complex care in community housing. Communities already engaged in creating supportive housing for persons with special needs will be the primary targets. This will allow for coordination with existing programs, which is viewed as the most effective way to provide linkage to those services needed and to identify those persons wishing/requiring alternative housing, with the ability to match them to housing units. The Department is aware of approximately 150 persons identified through the PASARR process who are in need of alternative living arrangements and who could form an initial referral pool of nursing home residents to benefit from this effort.

We will develop strategies not only to provide housing for this population, but also to access the supports needed to enable persons to live independently. The state housing initiative expects at least 150 units of newly available housing after three 3 years of effort. It is expected with the linkage to the Nursing Facility Transitions grant activities that additional units will be identified and specifically targeted to the nursing facility population. A last-resort transition fund, provided for in the grant, will help defray moving costs for extremely indigent individuals where other sources of public or private funds are not available.

Diversion. Two efforts will be piloted. First, the University of Michigan's Turner Geriatric Program will work to link hospital personnel with transition activities and local resources, and to assist individuals being discharged to return to, or to find an alternative home in, the community. The second effort will be funded by the state housing authority to assist residents of state-financed housing to "age in place," and, in coordination with the transition component and with Turner Clinic, work to fill vacancies in existing state-financed housing.

Education. This component will provide education, training, and technical assistance on specific aspects of the initiative to persons and entities identified through the other components.

Evaluation. We will develop a prototype for evaluating the effort, focused on cost/ benefit analysis, changes in quality of life, and "lessons learned."

NEW HAMPSHIRE

Grant Information

<i>Name of Grantee</i>	DHHS, Elders Division
<i>Title of Grant</i>	Community Wrap: Older Adult Wrap Around Services
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$770,000

Contact Information

Todd Ringelstein 105 Pleasant Street, Main Building Concord, NH 03301	603-271-5094	tringels@dhhs.state.nh.us
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Subcontractor(s)

Dartmouth Psychiatric Research Center	Keith Miles	603-271-8345
Riverbend Community Mental Health, Inc.	Carrie Hughes	603-228-2101
Pathways To Recovery—Merrimack County Mental Health Consumer Association	Karen Lewis	603-225-0310
University of New Hampshire- Institute on Disability	Mary Shu	603-228-2084
State of New Hampshire's Mental Health and Aging Advisory Council	David Hilton	603-271-5162

New Hampshire State Hospital to be decided.

Glenclyff Home for the Elderly to be decided.

Concord area nursing homes to be decided.

Target Population(s)

Individuals in the Concord region with mental illness who are currently in a nursing home, or in the state psychiatric facility receiving a nursing home level of care but are no longer in an acute phase of their psychiatric illness.

Goals

- Ensure stable community residence for older adults with complex, multiple problems who are currently residing in nursing homes or receiving nursing home level of care in the state psychiatric facility.
- Expand housing opportunities for people with mental illness and other disabilities in the Concord community and statewide.
- Develop a system for providing the services needed to transition people from institutions to a community residence.

Activities

- Identify service gaps for individuals seeking community-based residency.
- Develop and implement a “Wrap Around Services” program to assist individuals transitioning to the community.
- Develop funding options for housing, social, adult daily living, medical and mental health needs including the development of a 1915(c) Mental Health/Home and Community Based Waiver application.
- Enhance older adult outreach capacity through intense case management, community outreach, and strengthened advocacy.
- Hire a housing specialist to pursue available and affordable housing through state and federal housing benefits.

Abstract

The Department of Health and Human Services’ Division of Behavioral Health, in collaboration with the Dartmouth Psychiatric Research Center, Institute on Disability, Riverbend Community Mental Health Center, the New Hampshire Housing Finance Authority and Pathways to Recovery Peer Support Program, will work together to transition older adults with mental illness from nursing facilities to the community.

This 3-year program contains two interrelated initiatives targeted at “Wrap Around Services,” for transitioning older adults with mental illness from nursing facility settings to community-based settings and expanding housing opportunities for people with mental illness and other disabilities in the Concord community and statewide. The wraparound approach has proven to be very effective in coordinating and delivering care when used with children diverted from, or transitioned out of, institutional placements, and has recently been shown to be similarly effective with older adults.

The goal of the project is to ensure that adequate and appropriate services and housing are delivered to ensure stable community residence for older adults with complex, multiple problems who are currently residing in nursing homes or are receiving a nursing home level of care in the state psychiatric facility.

Year 1 of the project will include a review and analysis of the Minimum Data Set in the state, a review and analysis of service gaps for individuals seeking community-based residency, and preparation of a waiver to support these specialized services. In year 2 we will submit the waiver application and plan the Wrap Around Services demonstration. In year 3 we will implement and evaluate the Wrap Around Team that includes a local Mental Health Peer Support Group with ten individuals from the Concord region.

Throughout the 3 years, a regional and statewide strategy to improve the availability of affordable and accessible housing will be implemented. Also over the 3-year period, the project process and outcomes will be documented in an evaluation provided by the New Hampshire Dartmouth Psychiatric Research Center.

TEXAS

Grant Information

<i>Name of Grantee</i>	ARCIL
<i>Title of Grant</i>	Texas Independent Living Partnership
<i>Type of Grant</i>	Nursing Facility Transitions, Independent Living Partnership
<i>Amount of Grant FY 2001</i>	\$308,178

Contact Information

John Meinkowsky, Project Director 512-832-6349 arcil@arcil.com
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Austin, TX 78753
www.arcil.com/tilp.html

Subcontractor(s)

None.

Target Population(s)

People with all types of disabilities, of all ages, in nursing facilities and those at risk of nursing facility placement.

Goals

- Expand upon successful outreach activities to identify people with disabilities of all ages in nursing facilities who are seeking to transition to the community with appropriate services and supports.
- Develop and implement components of training targeted to state agency staff, consumers, volunteers, advocates, and private service providers to address barriers to community transition.
- Develop lasting partnerships and implement systemic changes that supplement the State's infrastructure.

Activities

- Coordinate annual conferences of CIL staff, state agency staff, and partners.
- Develop and disseminate materials to replicate "best practices" for identifying consumers for community transition.
- Participate in ongoing training activities in each of the 11 state regions.
- Present specific recommendations for local, state, and national policy changes.

Abstract

The Texas Independent Living Partnership is a cooperative effort of the Texas Association of Centers for Independent Living (TACIL), the Texas Health & Human Services Commission (HHSC), and the Texas Department of Human Services (TDHS). Centers for Independent Living (CILs) in Texas and state agencies assist people with disabilities who want to move from nursing facilities to their own homes in the community. The project will work with state agencies, community organizations, and advocacy groups who serve children and adults of all ages with all types of disabilities.

TACIL represents 11 organizations operating CILs in 18 communities. HHSC is the State Medicaid Agency and leads the state's "Promoting Independence" initiative. TDHS is the state agency that funds nursing facilities and many of the state's community-based long-term care programs. Organizations serving children with disabilities, individuals with specific disabilities, and elderly individuals have agreed to help with outreach materials, training activities, and recommendations for changes to the long-term care system.

WASHINGTON

Grant Information

<i>Name of Grantee</i>	Department of Social and Health Services
<i>Title of Grant</i>	Supported Transitions
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$770,000

Contact Information

Kristina Smock, Program Manager Home and Community Programs P.O. Box 45600 Olympia, WA 98504-5600	360-725-2551	smock@dshs.wa.gov
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Subcontractor(s)

Resources for Individual & Family Supports	Nancy Martin	360-769-2220
Center for Independence	Jim Lindley	253-845-5187
Career Connections	Sue Warwick	509-928-0423
Norma Cossel	Norma Cossel	360-293-4293
Cascade Christian Service	George Beanblossom	360-714-9355
Workforce Dynamics	Sue Ferguson	503-292-2828
Mike Nelson	Mike Nelson	253-474-3117
Referral & Temp, Services	Patrick Farrell	253-851-7596
Independent Living Specialist	Laura Bean	206-612-6300
Service Alternatives	Kate Dohr	360-678-6381
Keys to Advancement	Elaine Hoefs	877-781-1010

** This list continues to grow as we develop the independent living contractor system.*

Target Population(s)

Individuals under the age of 65 living in nursing facilities throughout the state.

Goals

- Strengthen the capacity of independent living providers, centers, and contractors to provide support and technical assistance regarding independent living and consumer-directed services.

- Expand access to accessible, affordable housing for people transitioning out of nursing facilities.
- Improve the provision of assistive technology services necessary to live in the community.
- Develop a system for planning comprehensive individualized services to support the transition from nursing home to community residences.

Activities

- Organize and partner with independent living consultants to provide peer support, skills training, and advocacy.
- Collaborate with housing authorities and other entities to increase the options for affordable and accessible housing.
- Conduct a study of the state's durable medical equipment program.
- Enhance the resources for assistive technology.

Abstract

Washington State Department of Social and Health Services—Aging and Adult Services Administration will use grant funds to further its efforts in moving clients from nursing homes to less restrictive settings in the community. We expect to support up to 300 people under the age of 65, who have a variety of disabling conditions or chronic illnesses. Funds will be used to develop a system of supports aimed at removing the barriers that keep these people in nursing homes.

We will develop relationships with housing authorities and related entities throughout the state to share information and collaborate in developing systems for referral and support. Three housing authorities in the state share the Access 2000 Section 8 vouchers that are dedicated to people leaving nursing facilities. Processes and practices developed in those communities will provide a foundation for improving access to housing throughout the state.

A second thrust of the grant is to cultivate and support the capacity of independent living consultants to provide individualized support focused on living in the community. This will be accomplished through contracted services on a fee-for-service basis. Nursing facility social workers will develop a plan with the resident to achieve desired outcomes in moving to the community and connect individuals with consultants best suited for particular needs. The consultants will provide peer mentoring, skills training, advocacy, and technical assistance on an array of topics such as managing personal assistants, budgeting, paying bills, etc.

Third, we will augment the provision of durable medical equipment so that people are able to obtain an appropriate type and quality of assistive and adaptive equipment before leaving the nursing facility. This effort also includes a study of the durable medical equipment program to determine utilization rates, regional differences, and systems issues.

WEST VIRGINIA

Grant Information

<i>Name of Grantee</i>	Department of Health and Human Resources
<i>Title of Grant</i>	Transitioning to Inclusive Communities (TIC)
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$551,678

Contact Information

Stephen Mullins, Director Office of Behavioral Long-Term and Alternative Health Care 350 Capitol Street, Room 251 Charleston, WV 25301-3706 www.ced.wvu.edu/TIC	304-558-1448	stephenmullins@wv.dhhr.org
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Subcontractor(s)

West Virginia University Center for Excellence in Disabilities	Sally Burchfiel	304-293-4692
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Target Population(s)

Individuals of all ages with disabilities or long-term illness who reside in nursing facilities and/or segregated settings or are at risk of segregated placements.

Goals

- Increase information on community resources, supports, and services to enhance informed choices for community living for persons with disabilities or those with long-term care needs.
- Identify persons who wish to transition from nursing facilities into communities and identify necessary services and supports.
- Develop systems of peer supports and services to improve the transition process to inclusive communities.
- Identify barriers in Medicaid/Medicare service plans and waiver programs and recommend changes to support community living.
- Implement transitional support models and evaluate cost effectiveness and consumer satisfaction.

Activities

- Identify persons wanting to transition by developing informational and educational programs that provide guidance and build advocacy and self-determination skills for consumers, family members, and service providers.
- Develop a Consumer Oversight Commission that participates in grant activities, as well as a process to increase community supports in areas such as housing, education, attendant services, and in-home health care.
- Utilize, evaluate, and modify the Life Choices Assessment tool by conducting over 100 assessments and Person-Centered Planning for those interested in transitioning to the community or avoiding placement in nursing facilities.
- Develop and coordinate training for the development of Transition Support Teams statewide.
- Create a person-centered planning discharge and referral instrument that provides community options and resources and develops a data base that can be used to determine community service and support needs.

Abstract

The Transitioning to Inclusive Communities (TIC) Project will enable individuals who reside in nursing facilities or other segregated environments, or who are at risk of moving to such facilities, to transition to community residences. This goal will be accomplished through a number of activities. We will provide information resources for people with disabilities or long-term illnesses and their families, including a toll-free phone line, a web site, training, and a public awareness multimedia campaign. This information will assist the individuals considering transition to make informed choices regarding community living options.

We will identify individuals interested in transition through responses to disseminated information and training, as well as through a person-centered Life Choices Assessment Tool, used for both transitioning from and avoiding nursing or congregate facilities. Self-determination and self-advocacy skills will be enhanced through collaborations with advocacy organizations and statewide training. Community transition options will be increased through contracts with advocacy and consumer support groups to provide model peer supports and “trial” community transition choice options.

Discharge planning and intake will be augmented with a person-centered system of supports. A Transition Support Team will be modeled at nursing and congregate settings as well as with rehabilitation hospital discharge and nursing home intake personnel. This interdisciplinary support team is made up of the individual transitioning, professionals, family and friends, community members, and volunteers. Technical assistance will be provided so that a selected number of individuals can develop their own consumer-directed Transition Support Team.

Finally, the TIC Project will build additional community supports through funding nonprofit advocacy, consumer or community groups to demonstrate the use of peer supports and services in the transitioning and diversion processes. Small amounts of additional funds will demonstrate the importance of assistive technology or home start-up funds as people transition.

Consumer direction and evaluation for the TIC Project is provided through a 25-member Consumer Oversight Commission, through ongoing follow-up, and through a consumer satisfaction survey in the last year of the grant.

WISCONSIN

Grant Information

<i>Name of Grantee</i>	Great Rivers Independent Living Center
<i>Title of Grant</i>	Nursing Facility Transitions Project
<i>Type of Grant</i>	Nursing Facility Transitions, Independent Living Partnership
<i>Amount of Grant FY 2001</i>	\$450,000

Contact Information

Jennifer Staab, Transition Coordinator 608-787-1111 jennifer.staab@greatrivers.org
 4328 Mormon Coulee Road
 La Crosse, WI 54601
www.greatrivers.org

Subcontractor(s)

<i>Access to Independence</i>	<i>Wendy Hecht</i>	<i>608-242-8484</i>
<i>Center for Independent Living of Western Wisconsin</i>	<i>Kay Sommerfeld</i>	<i>715-233-1070</i>
<i>IndependenceFirst</i>	<i>Deb Langham</i>	<i>414-291-7520 X204</i>
<i>Midstate Independent Living Consultants</i>	<i>Becky Paulson</i>	<i>715-369-5048</i>
<i>North Country Independent Living Center</i>	<i>Dee Truhn</i>	<i>715-392-9118 X19</i>
<i>Options for Independent Living</i>	<i>Kathryn Barry</i>	<i>920-490-8270 X183</i>
<i>Society's Assets</i>	<i>Karen Olufs</i>	<i>262-637-9128</i>

Target Population(s)

Any person with a disability or long-term illness residing in a nursing facility, ICF-MR, or state center for 90 days or more, who would like to receive services in the community.

Goals

- *Identify and address methods to eliminate barriers that limit or prevent persons with disabilities or long-term illnesses from living independently in the community of their choice.*
- *Facilitate successful community placement for 210 persons with various disabilities and ages statewide who are currently living in nursing facilities.*
- *Enhance existing Independent Living Center peer support programs to provide information and assistance to consumers, families, and guardians regarding transitions.*

- Collaborate with local housing authorities and other housing service providers and business partners to access and develop resources to increase housing options for people using transition services.

Activities

- Develop and implement relocation plans for consumers residing in nursing facilities who want to move to the community.
- Train and support transition specialists and peer support volunteers.
- Set up a web based chat group to connect ILC transition specialists with the Department of Health and Family Services (DHFS).
- Conduct statewide outreach to individuals in nursing facilities and the agencies with which they may come into contact.
- Develop caregiver support groups.
- Train ILC staff statewide to assist individuals in nursing facilities with relocation planning.

Abstract

The Transitions Project will create an effective methodology and practice to reduce and eliminate the existing barriers to relocation from nursing facilities to community living throughout the state of Wisconsin. Funds will also be used for training and to support a cadre of transition specialists and peer support volunteers.

As an Independent Living Center (ILC), Great Rivers provides services to individuals of all ages with all types of disabilities. All of the eight ILCs in Wisconsin have successfully participated in the previously funded Nursing Home Relocation Project (Homecoming) over the last 2 years and bring a great deal of knowledge and expertise to this new project. They have extensive experience in providing outreach to relevant agencies and nursing facility residents who desire community living, and in providing technical assistance on home modifications and assistive technology. Additionally, they have in-depth knowledge of required community resources such as local housing authorities, personal care providers, transportation services, and local, state, and federal funding options. They also have a successful partnership with the Wisconsin DHFS.

The eight ILCs have experience working within Wisconsin's long-term care system, which includes the Community Options Program (COP), Medicaid state plan services, Medicaid Waiver Programs, Family Care, Badger Care, and Pathways to Independence. All ILCs currently have a list of identified residents living in nursing facilities who are waiting for community living. The ILC staff are knowledgeable of the barriers that prevent their relocation and have access to information and services that could reduce or eliminate those barriers. The Transitions Project will identify and recommend how to implement the changes needed to address the relocation barriers and provide the information and support to sustain a successful relocation.

WISCONSIN

Grant Information

<i>Name of Grantee</i>	Department of Health and Family Services Division of Supportive Living
<i>Title of Grant</i>	Homecoming II
<i>Type of Grant</i>	Nursing Facility Transitions, State Program
<i>Amount of Grant FY 2001</i>	\$800,000

Contact Information

Gail Proptom Long Term Care Policy Analyst 1 West Wilson, P.O. Box 7851 Madison, WI 53707-7851	608-267-2455	propsgf@dhfs.state.wi.us
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Subcontractor(s)

None at this time.

Target Population(s)

Individuals who are currently in a nursing home or other institution from any target group (frail elderly, physical disability, developmental disability, or serious mental illness) and who meet functional and financial eligibility criteria for available funding sources. The project will give special emphasis to working with individuals who have developmental disabilities or serious mental illness.

Goals

- Facilitate the transition of up to 400 individuals from nursing facilities to a successful community placement during the project period.
- Increase the flexibility and responsiveness of the current system to redirect available resources to enable persons with long-term care needs to have the opportunity to live successfully in the least restrictive setting appropriate to their needs.

Activities

- Identify individuals in institutions who want to move to the community and work with all stakeholders to develop care plans and funding options to enable relocations to occur.
- Develop a systematic process for ongoing identification and relocation of individuals who want to move from institutions to the community.
- Develop strategies to ensure that resources are available to support people to live in the community.
- Develop strategies for recruiting and maintaining a capable long-term care workforce.
- Fund local projects to systematically address housing issues of individuals with disabilities.

Abstract

Wisconsin's nursing home transition project, entitled *Homecoming II*, builds on the experiences of a nursing home transition grant received in 1999. The original projects focused on individuals with physical disabilities and frail elders and the development of relationships with Independent Living Centers as partners in outreach and relocation support. Wisconsin will build on the original *Homecoming* grant by expanding the target groups and increasing focus on system building for future activities.

The *Homecoming II* project will improve community-integrated services in the short term for 400 consumers who are currently in institutions, and over the long term through systems changes that will facilitate the relocation of additional individuals in a more systematic way. Particular attention will be paid to persons with serious mental illness living inappropriately in nursing homes and to persons with developmental disabilities living in Intermediate Care Facilities for Mental Retardation, while continuing the activities that successfully relocated residents who are elderly or have physical disabilities. In the new project, the Independent Living Centers will continue their current role with their own Nursing Facility Transitions Grant from CMS.

The outcomes Wisconsin anticipates for *Homecoming II* are:

- Up to 400 individuals will be relocated from nursing homes and other institutions.
- Relocated individuals will have most of their needs and preferences met cost-effectively, as determined by consumer outcome interviews.
- Wisconsin has a system in place to use available resources so that people live in the least restrictive setting appropriate to their needs. Resources include outreach and identification, clinical expertise, peer support, and availability of service funding.
- Wisconsin has more local partnerships to provide readily available housing opportunities for individuals with disabilities.
- Wisconsin has an increasing supply of qualified direct care workers to meet the needs of its people with long-term care needs.

ALABAMA

Grant Information

<i>Name of Grantee</i>	Alabama Medicaid Agency, Long Term Care Division
<i>Title of Grant</i>	Sweet Home Alabama: Under Construction
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,000,000

Contact Information

Marilyn Ferguson, Director 501 Dexter Avenue Montgomery, AL 36103	334-242-5009	mferguson@medicaid.state.al.us
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Subcontractor(s)

Alabama Department of Senior Services	Dr. Melissa Galvin	334-242-5594
Alabama Department of Mental Health and Mental Retardation	Anne Evans	334-242-3706
Volunteer and Information Center	Doci Haslam	334-264-4636
Governor's Office on Disability	Rebecca Wright	334-353-0355

Target Population(s)

Persons with disabilities regardless of age or type of disability.

Goals

- Enhance access to home and community-based services through improved information dissemination and service coordination.
- Create and expand system-wide opportunities for consumer choice and control over home and community-based services.
- Expand resources for home and community-based services through effective planning, advocacy, and education.

Activities

- Develop a community-based information and referral clearinghouse through collaborative public/private partnerships.
- Develop and implement a required Service Coordination Core Training Module to cross-train Medicaid service coordinators in basic competencies and information.
- Complete and implement recommendations from a comprehensive study of the feasibility of a single point of entry and/or coordination for home and community-based services.
- Train, implement, mentor, and support person-centered planning (PCP) for consumers with developmental disabilities.
- Establish infrastructure for consumer input for consumers with mental retardation and/or developmental disabilities.
- Expand the Psychiatric Rehabilitation model to all community mental health centers and all units of state hospitals over a three-year period.
- Develop, implement, and evaluate a person-centered assessment tool and process as a basis for a consumer-directed system of senior services.
- Establish a permanent Disability/Aging Policy Advisory Group within the Medicaid Agency's Long Term Care Division to formalize the mechanisms for ongoing consumer input and enhanced coordination of services.
- Develop advocacy and informational materials to educate consumers and family members, policymakers, and others regarding the State's Olmstead Plan.
- Establish an Outreach and Education Unit within the Medicaid Agency's Long Term Care Division.

Abstract

Our proposal was developed in conjunction with the state's Olmstead planning process. This process is comprehensive, addressing the needs of people with disabilities and their families regardless of age or type of disability. It is also consumer-based, substantially involving people with disabilities and family members in planning and decision-making. The Olmstead Core Workgroup is a 40-member group, comprising state agencies, advocates, providers, and consumers and family members, with the Alabama Medicaid Agency serving as lead agency.

The Workgroup has drafted a unifying theme as a title for the Olmstead plan, designed to catch the imagination of the state's citizenry and policy makers: *Sweet Home Alabama: Under Construction*. It is an apt metaphor for the work we must do to build a cohesive system of supports that is predicated on community, real choice, and consumer direction. The architects of the proposed systems changes are its stakeholders, with special emphasis on the substantial and meaningful participation of people with disabilities and family members. The proposed grant activities are our building blocks, targeted to achieve enduring systems change in three areas: access, consumer choice/control, and expanded resources for home and community-based services.

ARKANSAS

Grant Information

<i>Name of Grantee</i>	Department of Human Services Division of Aging and Adult Services
<i>Title of Grant</i>	Real Choice for Enduring Change in Arkansas
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$1,025,000

Contact Information

Herb Sanderson, Director P.O. Box 1437, Slot S530 Little Rock, AR 72203-1437	501-682-8520	herb.sanderson@mail.state.ar.us
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Subcontractor(s)

None at this time.

Target Population(s)

Adults age 19 and older.

Goals

- Achieve a better balance of spending between institutions and home and community settings.
- Increase the availability of in-home workers.
- Improve or maintain the health of elderly persons who are dual-eligibles.
- Increase consumer control over their services.

Activities

- Identify successful strategies to recruit and retain in-home workers, including those that focus on wages, benefits, training, and the establishment of a career path.
- Establish a worker registry.
- Develop a replicable model for a voluntary Medicaid/Medicare integrated system that efficiently manages the costs of services.
- Provide technical assistance regarding consumer self-determination practices to consumers and advocacy organizations.
- Develop an assessment process based on consumer preferences.

Abstract

The Real Choice project will address a number of problems Arkansas experiences in delivering long-term care services. Relevant agencies have come together with consumer groups and other public and private partners to plan for systems change that will promote informed consumer choice and higher quality services. The project will address issues related to access, availability, quality, value, and consumer participation.

The Real Choice grant for Arkansas will address the need for a single point of contact for home and community-based care, timely and flexible eligibility determination, ease of access to services, and appropriate determination of services people want and need. Strategies we intend to employ are the use of federal options over more restrictive state options; a feasibility study to integrate Medicare and Medicaid services for seniors; training staff across divisions of the Department of Human Services (DHS) to promote understanding of alternatives available; an education outreach program to community resource staff; development of new assessment tools to determine optional settings for people entering the system and those already institutionalized; a study to explore the options for providing insurance to front line workers; a public awareness campaign to elevate the status of such occupations with the general public; development of a state worker registry; and strengthening of individual consumers and consumer advocacy groups in effective action at the law and policy-making levels.

Significant and sustainable outcomes will include a system that encourages greater consumer control and choice and services that will enable people to enjoy improved overall health and long-term care in their communities for a longer period.

DELAWARE

Grant Information

<i>Name of Grantee</i>	Delaware Health and Social Services
<i>Title of Grant</i>	Assistive Technology Access: Infrastructure for Community Living
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$1,200,000

Contact Information

Joseph B. Keyes, Ph.D. Director, Professional Services Division of Developmental Disabilities Services Jesse Cooper Building, P.O. Box 637 Dover, DE 19903	302-739-4452	jkeyes@state.de.us
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Subcontractor(s)

Delaware Assistive Technology Initiative University of Delaware	Beth Mineo Mollica, Ph.D.	302-651-6836
Center for Disabilities Studies University of Delaware	Theda M. Ellis	302-831-4450

Target Population(s)

People with one or more disabling conditions. A more specific subpopulation is individuals with a disability currently receiving services through various state agencies.

Goals

- Increase awareness and knowledge of assistive technology (AT) at all levels.
- Streamline and improve access to funding options.
- Expand the range of assistive technology access options and alternatives.
- Establish a comprehensive tracking system for assistive technology.

Activities

- Conduct a needs analysis.
- Conduct an awareness campaign and specific training activities for various target groups.
- Develop a web site.
- Revise policies that decrease access to assistive technology and expand funding options for assistive technology.
- Design and implement a tracking system for assistive technology.

Abstract

Assistive technology (AT) often makes it possible for people with disabilities to move from institutional to community living arrangements or to continue to live in their own homes as their support and service needs change. Numerous studies and stakeholder polls reveal that Delaware residents with disabilities encounter barriers in their attempts to obtain the AT they need. With this project, the State of Delaware will strengthen its support infrastructure for people with disabilities by increasing access to AT devices and services. Doing so expands the options afforded to consumers—a central tenet of person-centered planning—and enables the service infrastructure in Delaware to become increasingly consumer responsive.

Building on several extensive planning processes undertaken in the past year (involving consumers, providers, state agencies, and advocates)—and using a groundbreaking initiative led by the Delaware Division of Developmental Disabilities Services as a model—a Work Group comprising key stakeholders developed a 3-year plan. Grant activities over the 3 years will lead to: significant increases in awareness of the benefits of technology options; opportunities to explore technology options prior to making purchase decisions; provider sophistication in facilitating technology selection and use; consumer sophistication in selecting and using AT; the comprehensibility and comprehensiveness of policies impacting AT access; consumer and provider access to a range of supports that facilitate efficient and appropriate AT access; and accessibility of state information and services for people with disabilities.

The activities of this project will improve stakeholder awareness, knowledge, and skills relative to AT and to the infrastructure supporting technology exploration, acquisition, and use. These improvements will help ensure that AT will become a readily available component of community-based supports and services in the years following project completion.

FLORIDA

Grant Information

<i>Name of Grantee</i>	Florida Department of Management Services Americans with Disabilities Act Working Group
<i>Title of Grant</i>	Real Choice Partnership Project
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,000,000

Contact Information

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Subcontractor(s)

Yet to be awarded.

Target Population(s)

Children and adults of any age who have a disability or long-term illness, who currently rely on long-term support systems, and who may be at risk due to insufficient community supports and/or who may be inappropriately placed in a restrictive setting.

Individuals of any age residing in three regional pilot project sites who have a disability or long-term illness, and who are eligible for services or at risk of institutionalization.

Goals

- Create operational linkages among key stakeholders that result in improved communication, and better coordination of services for people with disabilities and long-term illnesses.
- Improve the delivery of services to consumers by increasing access to providers and streamlining Medicaid services provided through four major waiver programs: the Aged and Disabled Adult Waiver, the Project AIDS Care Waiver, the Traumatic Brain Injury and Spinal Cord Waiver, and the Assisted Living for the Elderly Waiver.
- Create a comprehensive single point of contact/inquiry to obtain information and links to state and local resources (Clearinghouse on Disability Information).
- Implement three pilot projects to develop community capacity to assist people with disabilities and long-term illnesses to live in integrated community settings of their choice when appropriate.

Activities

- Identify unnecessary barriers in state or federal policies and regulations that hinder or limit the effectiveness of waiver programs, and develop recommendations and implement strategies to address these barriers.
- Expand the implementation of Florida's statewide Clearinghouse on Disability Information to function as the single point of data collection and information access on all aspects of the project.
- Establish a statewide educational campaign on the Clearinghouse program, and develop a consumer feedback mechanism to track consumer satisfaction with the Clearinghouse services.
- Analyze the benefits and costs of a statewide automated and accessible benefits screening program for professionals and consumers.
- Create local grassroots long-term care resource networks in three demonstration areas, which will provide technical assistance and local community resources to address barriers and share best practices;
- Create a housing initiative involving the disability and aging communities, housing administrators, and providers to increase housing choices for people with disabilities and long-term illnesses. This initiative will:
 - Establish partnerships and cross-train on the housing needs of people with disabilities and long-term illnesses and how to access housing resources;
 - Develop an effective tool to assess the need for home modifications and assistive technology;
 - Work with public housing agencies to submit mainstream voucher applications to HUD to increase the number of Section 8 vouchers available for people with disabilities and long-term illnesses; and
 - Coordinate existing housing education initiatives to ensure that people with disabilities and long-term illnesses are included.

Abstract

Florida's Real Choice Partnership Project is designed to implement improvements in community long-term support systems that will enable people of all ages with disabilities or long-term illnesses to live and participate in their communities. The project is organized around four primary goals or objectives: create operational linkages among the key state agency stakeholders and service providers; streamline the delivery of services to consumers by increasing access to providers and coordinating services covered under Medicaid Waiver Programs; create a comprehensive single point of contact/inquiry for people with disabilities and/or long-term illnesses, caregivers, and service providers to obtain information and links to state and local resources (Clearinghouse on Disability Information); and develop community support networks and resources to assist people with disabilities and long-term illnesses to live in an integrated community setting.

GUAM

Grant Information

<i>Name of Grantee</i>	Department of Public Health and Social Services Division of Public Health
<i>Title of Grant</i>	Real Choice Program
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$673,106

Contact Information

Peter John D. Camacho Chief Public Health Officer P.O. Box 2816 Hagatna, Guam 96932	671-735-7305	pjcam@mail.gov.gu
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Subcontractor(s)

Department of Integrated Services for Individuals with Disabilities
The Guam Developmental Disabilities Council

Target Population(s)

Persons with disabilities and long-term illnesses.

Goals

- Increase community inclusion for persons with disabilities through comprehensive community services planning and reform.

Activities

- Consolidate state plans from all service and advocacy agencies into a coordinated comprehensive systems change plan to be used as a blueprint to move from an agency-centered service model to a person-centered model.
- Develop a cadre of professionals who have been trained in person-centered systems of service.
- Design and develop a universal screening and tracking database and related forms.
- Setup and maintain an information system.
- Design and develop a screening and tracking form and a database for an individualized budgeting program.

Abstract

The Guam Real Choice Program will address the challenges that the current service delivery of care system faces. The one most often-repeated concern is the fragmented nature of the system that provides services to persons with disabilities. There are a host of governmental and nongovernmental organizations that provide services for individuals with disabilities. These services are offered based on the respective agency's perception of what services may be needed and the resources it has available to provide those services. This agency-centered model is useful but often does not meet all the needs of the individual and the family. Another concern is that consumers may not have been involved in the planning and development stages prior to implementation of the service.

The Guam Real Choice Program, along with the major stakeholders in the services delivery arena including consumers, will develop a comprehensive system of services and supports that will be person-centered in all aspects. One important component of this endeavor will be to develop a system to accurately identify individuals with developmental disabilities. The island's Chief Executive, Legislators, and others can use this registry in developing related policies. Another focus area for the project is to develop an on-island training capacity to ensure a readily available pool of support resources for consumers. Additionally, it is also critical to develop a program that provides health care clinicians with the appropriate knowledge base to ensure a holistic continuum of care across the life cycle. It is critical that public awareness also be addressed to ensure successful community inclusion of persons with disabilities.

HAWAII

Grant Information

Name of Grantee	Department of Human Services
Title of Grant	Hawaii Real Choices Partnership
Type of Grant	Real Choice Systems Change
Amount of Grant FY 2001	\$1,350,000

Contact Information

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Subcontractor(s)

University of Hawaii Center on Disability Studies	Robert A. Stodden	808-956-9199
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Target Population(s)

Persons who are aging and those with disabilities who require long-term supports to function in their community of choice.

Goals

Involve all stakeholder groups and maximize consumer participation in a collaborative systems change process through consumer-majority collaborative bodies responsible for developing policies, procedures, and practices.

Enhance access to long-term care services, promote consumer choice and self-determination, and improve service quality by developing and demonstrating a cross-agency, cross-disability Web based single entry point (SEP).

Provide primary/secondary consumers and agency personnel with essential attitudes, skills, and knowledge for achieving increased consumer choice and self-determination through use of the Web based SEP.

Activities

- Establish and support a governing council and workgroups with broad stakeholder representation.
- Support the governing council and its workgroups to develop and submit background and language for legislation and program guidelines enabling desired systemic changes.
- Develop and implement a Web based SEP and develop strategies to ensure sufficient and enduring resources to maintain the Web based SEP beyond the end of Hawaii ACCESS Project funding.
- Assess training and technical assistance needs of participating stakeholder groups, and develop and implement technical assistance activities to meet identified needs.
- Conduct ongoing evaluation of effectiveness of training and technical assistance activities.

Abstract

The Hawaii Real Choices Partnership will involve all key stakeholder groups in developing, demonstrating, and institutionalizing one of the nation's first cross-agency Web based Single Entry Point (SEP) that will provide consumers with in-depth, up-to-date information on ALL their available options, including those offered by private as well as public agencies.

This innovative SEP will employ the latest computer networking and Web technologies to provide the following consumer-friendly features: an interactive assessment process to help consumers identify services for which they are eligible; a unified database showing all long-term care services offered by the state, counties, and private organizations, with open slots listed according to geographical location; and a quality assurance component that will identify service gaps by tracking service requests and allow consumers to rate the services they receive.

To maximize consumer input into all aspects of the project and promote collaboration and coordination among all stakeholders, a collaborative systems improvement process, as demonstrated to be effective in numerous other systems change efforts, will be implemented. This process will be used to guide the activities of a partnership governing council, which will have directive authority over the project and will establish work groups to address critical topics.

The council and work groups will be chaired by a consumer (co-principal investigator for the project) and will have at least 51% consumer membership (consumer members will include primary consumers, family members or others concerned for their well-being, and representatives of consumer and family organizations). Other council members will include the heads of the public and private service providing agencies, including the DHS Director, serving as Principal Investigator, heads of four DHS divisions, two Department of Health divisions, and the Executive Office on Aging.

The overall goal of the Hawaii ACCESS Project is to design and implement effective and enduring improvements in community long-term support systems for all children and adults with disabilities or long-term illness, reflecting increased access to information, choice, and quality services and supports consistent with their community living preferences and priorities.

IDAHO

Grant Information

Name of Grantee Department of Health and Welfare
Division of Family and Community Services
Idaho State University Institute of Rural Health

Title of Grant Real Choices

Type of Grant Real Choice Systems Change

Amount of Grant FY 2001 \$1,102,148

Contact Information

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Mardell Nelson
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Subcontractor(s)

Idaho State University Institute of Rural Health Dr. Beth Stamm 208-282-4074

Target Population(s)

All people with disabilities and long-term illness.

Goals

- Increase access in all forms.
- Increase availability and adequacy of services.
- Increase or maintain value of services across the system.
- Increase or maintain quality of services across the system.

Activities

- Conduct a statewide anti-stigma campaign.
- Conduct a needs and resources assessment.
- Conduct an economic analysis of current service utilization.
- Implement a community development project.
- Conduct an effectiveness study to test and refine a community based plan.

Abstract

This project will create enduring systems change in two phases: (Phase 1) a statewide anti-stigma campaign and a needs and resources assessment, culminating in a plan for change; and (Phase 2) an effectiveness study to test and refine the plan. There are four objectives: increase access in all forms, increase availability and adequacy of services, increase (or maintain) the value of services across the system, and increase (or maintain) the quality of services across the system.

The objectives will be achieved by an anti-stigma campaign that will pave the way for more successful community integration. A statewide assessment of needs and resources will establish a baseline of needs and resources. An economic analysis of the current system, including the Medicaid program, will seek to maximize appropriate funding strategies and leverage available funds. A community development project to examine the political and fiscal feasibility of addressing inadequate access to resources will approach this as a community development problem, not a health care problem, and an effectiveness study will determine the quality and value of the project. The final product will be a plan for statewide implementation, to obtain consumer and stakeholder input, and a monitoring system for continuous quality improvement.

ILLINOIS

Grant Information

<i>Name of Grantee</i>	Illinois Department of Human Services
<i>Title of Grant</i>	Illinois Systems Change Project
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$800,000

Contact Information

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Subcontractor(s)

Not yet identified, but likely to include community service delivery agents (CSDAs).

Target Population(s)

People with physical disabilities, people with developmental disabilities, people with mental illness, and elderly people with all types of disabilities.

Goals

- Create a system that fosters ongoing communication between the various agencies and community service delivery agents (CSDAs), including Area Agencies on Aging, Case Coordination Units, Mental Health Networks, and Centers for Independent Living (CILS) in Rockford and Southern Illinois, and establish processes whereby the CSDAs use self-assessment to identify areas of change, inform all partners of the needs for change, and modify procedures and policies on an ongoing basis.
- Create more effective strategies for developing, locating, and maintaining affordable, accessible housing resources.
- Identify and develop tools for consumers and community service delivery agents to assist people, if they choose, to successfully transition from institutional settings to appropriate community settings.
- Establish a framework of successful long-term community supports for people once they have transitioned from institutional settings into the community.

Activities

- Develop a Community Partner Fund that will pay for the costs of the Community Service Delivery teams in 2 areas (Rockford and Southern Illinois).
- Provide start-up grants to individuals to enable them to move into the community in Rockford and Southern Illinois.
- Pay for a consultant to work with agency staff to develop a format and procedural guidelines for developing person-centered plans.
- Pay for a contractor to make information system changes.
- Provide funding for any technical assistance and training in areas such as assistive technology and other areas identified by the CSDAs.

Abstract

This grant will enable the Illinois Department of Human Services to enhance the existing system of long-term supports and services by emphasizing a consumer-driven approach to community integration with the Systems Change Project. The project will focus on Southern Illinois and Rockford.

The Systems Change Project will foster ongoing communication between the various state agencies and CSDAs and establish processes whereby the CSDAs use self-assessment to identify areas in need of change, inform all partners of the need for change, and modify procedures and policies on an ongoing basis. It will create more effective strategies for developing, locating, and maintaining affordable, accessible housing resources and assistive technology. The project will identify and develop tools for consumers and CSDAs to assist people who choose to move to successfully transition from institutional settings to appropriate community settings and will establish a framework for successful long-term community supports for people once they have transitioned.

Putting consumers at the center of all efforts to redesign systems and improve access to community-based living opportunities is key to Illinois' ability to sustain any advances achieved in this project. The outcome is a coordinated system of long-term support that is person-centered and provides an array of services based on the persons' strengths, desires, and needs.

This project will lay the groundwork for an enhanced quality of life for individuals at risk of, or currently living in, institutional settings. Its most significant outcome will be to enable individuals to remain in or return to the community.

A Consumer Task Force will be involved in this project and has been since its inception. It is made up of people with different types of disabilities or parents of people with disabilities. A number of partnering agencies will also be involved, as part of a state Inter-Agency Team. They include: DHS Offices of Rehabilitation Services, Developmental Disabilities, and Mental Health; Clinical Administrative and Program Support; Child Care and Family Services; Department on Aging; the Illinois Housing Development Authority; the Department of Public Aid; and the State's Medicaid funding authority. The Team will serve as the primary vehicle of coordination among and between the government partners, CSDAs and consumers.

IOWA

Grant Information

<i>Name of Grantee</i>	Iowa Department of Human Services, Division of MH/DD
<i>Title of Grant</i>	Iowa's Real Choice Program
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$1,025,000

Contact Information

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Subcontractor(s)

To be determined.

Target Population(s)

Persons with disabilities and long-term illnesses currently living in institutional settings and those at risk of entering institutions.

Goals

- Move the disability services system away from the traditional medical model of evaluation and placement of individuals toward a system that is driven by meaningful and informed consumer choices and is responsive to consumer-identified needs.
- Develop and provide coordinated transition and community support systems to facilitate movement from institutional to community settings and support individuals living in integrated community settings to avoid institutional placement.
- Design an individualized, consumer-centered process to assess individual preferences and abilities that will allow consumers to make informed choices about their living environment, the services they receive, the types of support they use, and the manner in which services are provided and funded.

Activities

- Identify systems for identification of all persons with disabilities currently living in institutional settings and those at risk of entering institutions.
- Identify and train Community Living Specialists to assist consumers with transition activities and support them in community living.
- Develop an evaluation process to monitor systems change efforts.
- Develop and implement an individualized assessment tool and process that identifies strengths and barriers and emphasizes personal choice and preferences.
- Provide information to individuals with disabilities and long-term illnesses to assist them in accessing needed resources, services, and supports in the most integrated setting appropriate to their needs and consistent with their preferences, including information on individual rights, self-advocacy, and appeal rights.
- Provide information to parents and other family members, guardians, and direct service staff on the service system and living options, individual rights, informed choice, advocacy, and appeal rights.
- Provide information and training to service providers, service coordinators, medical professionals, and policy makers.
- Identify and pursue needed policy changes to increase the flexibility of and simplify access to disability-related services and funding.
- Establish an information and referral system to assist individuals to access services and supports before they are at imminent risk of institutionalization.
- Establish and implement a coordinated system of transition services and community-based supports for individuals accessing less restrictive living options.
- Establish and implement a coordinated system of crisis prevention and intervention services to prevent unnecessary institutional admissions.

Abstract

The grant will be used to develop and improve community support systems by establishing a flexible, consumer-centered, individual assessment process emphasizing consumer preferences and by developing a coordinated system of transition and community support services.

The project will use the expertise and experiences of numerous state agencies, local governments and providers, consumers and their family members, and advocates of the disability system as part of The Oversight and Implementation Committee for the Iowa Plan for Community Development. A steering committee was developed in January of 2001. The "Olmstead Real Choices Consumer Taskforce," as it has been known since a name change in 2002, has been operational since June of 2001 and has been involved in development of the original and amended grant applications. More than 50 percent of the membership is made up of people with disabilities who are also consumers of disability-related services or family members of adults and children with disabilities.

KENTUCKY

Grant Information

<i>Name of Grantee</i>	Kentucky Cabinet for Health Services
<i>Title of Grant</i>	Real People: Real C.H.O.I.C. E.S—Citizen Monitoring, Housing Options and Investing in Creative Educational Solutions
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,000,000

Contact Information

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Subcontractor(s)

Center for Accessible Living	Jan Day	502-589-6620
Council on Mental Retardation	April Duval	502-584-1239
ARC of Kentucky	Patty Dempsey	502-875-5225
University of Kentucky/IHDI	Ron Harrison	859-257-1714
Eastern Kentucky University/TRC	Elizabeth Wachtel	859-622-2262
Kentucky Housing Corporation	Natalie Hutcherson	502-564-7630

Target Population(s)

The general target population is individuals with disabilities. Each of the three major initiatives is targeting a specific population:

Citizen Monitoring Initiative. Individuals with mental retardation/developmental disabilities that are served by Supports for Community Living waiver providers throughout the state. The target population will expand to other individuals with disabilities in years two and three of the grant.

Housing/Nursing Home Transition Initiative. Individuals with disabilities residing in Louisville/Jefferson County (urban) and Murray/Calloway county (rural).

Workforce Initiative. Individuals with disabilities who receive services from providers trained under this initiative.

Goals

- Develop a system of citizen oversight in quality and consumer satisfaction for Kentucky's system of long-term supports by piloting an initiative for persons with mental retardation and other developmental disabilities.

- Increase individuals' ability to make an informed choice about where they will live, increase timely access to existing affordable community housing options and increase the stock of new affordable and accessible housing options while piloting an initiative that transitions individuals with disabilities to the community from nursing homes and other long-term care facilities.
- Improve the stability and quality of personnel and services to individuals with disabilities or long-term illnesses through the development of a competent and dedicated workforce.

Activities

Workforce Initiative. Create a consortium to develop recommendations for the development of curricula. Develop and implement seven curricula to train community-based direct service, supervisory, and administrative staff. Place curricula in the Kentucky Virtual University system for use statewide.

Housing/Nursing Home Transition Initiative. Develop pilot projects in two regions of the state (urban and rural) to assess the availability and accessibility of housing and service options for individuals transitioning out of institutions into the community. Develop a marketing plan to inform discharge planners, community advocacy groups, and individuals about the pilot project.

Citizen Monitoring Initiative. Recruit and train consumers and family members to participate in a pilot project patterned on the existing state-funded Core Indicators Project. Recruit volunteer personal advocates for participants served by the Supports for Community Living waiver program.

Abstract

The citizen monitoring initiative has three components: 1) developing a protocol and training volunteer advocates, 2) recruiting and training two-person interview teams to solicit consumer satisfaction, and 3) engaging consumers and family members of services and supports to enhance current standard survey instruments.

The workforce initiative will develop a comprehensive credentialing system based on a common set of standards and training methods. This will be accomplished by hiring a full-time project director and the establishment of a consortium of institutions of higher education, persons with disabilities and community service providers.

The housing and nursing home transition initiative (conducted by the Center for Accessible Living, a Center for Independent Living) will establish two pilot projects in an urban and rural site to assist individuals with disabilities making the transition from a nursing home or other institutional setting to the community. The initiative will support the development of protocols and resources necessary to make this transition. Additionally, two specific projects at the state level involving the state housing finance agency (Kentucky Housing Corporation) will support this local effort. Grant funds will be used to develop a "standard plans" publication incorporating universal design principles, as well as to provide home modification funds to qualified individuals with disabilities through an existing program (the Kentucky Assistive Technology Loan Fund).

MAINE

Grant Information

<i>Name of Grantee</i>	Maine Department of Human Services Bureau of Medical Services
<i>Title of Grant</i>	Quality Choices for Maine
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,300,000

Contact Information

Christine Zukas-Lessard Deputy Director 11 State House Station, Bureau of Medical Services Department of Human Services Augusta, ME 04333 http://qualitychoices.muskie.usm.maine.edu/index.htm	207-287-3828	chris.zukas-lessard@state.me.us
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Subcontractor(s)

Edmund S. Muskie School of Public Service	Eileen Griffin	207/780-4813
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Target Population(s)

Generally, no specific target population. Some demonstrations will target specific populations, as yet undetermined. One project (evaluating wraparound services provided in schools) targets children with serious emotional disabilities.

Goals

- *Person-Centered Services.* Maximize options for choice and control of personal assistance services across programs. Provide more consumers with the administrative support infrastructure necessary or desired to exercise greater choice and control over personal assistance and other long-term services. Develop, demonstrate, and evaluate a model of flexible funding that enables consumers to access services from multiple state departments. Increase the effectiveness of services targeted to children with emotional, behavioral, or mental health needs in public schools.
- *Quality.* Identify and implement quality indicators for measuring quality of life and quality of care for children and adults with disabilities receiving long term services and supports. Demonstrate the feasibility and efficacy of interdepartmental collaboration on quality improvement for long-term services and supports.
- *Access.* Increase access to information about services and eligibility; housing; qualified direct care workers; recreational, social, and cultural activities; and transportation services.
- *Data.* Improve planning and implementation of services by integrating data across departments.

Activities

- Conduct a comparative analysis of Maine's PAS policies, develop recommendations for change.
- Develop an independent service organization.
- Conduct a flexible funding demonstration.
- Evaluate the wraparound services program underway in Portland Public Schools.
- Identify and implement quality indicators measuring quality of care and quality of life.
- Identify and conduct two interdepartmental collaborative quality improvement projects.
- Develop a web site providing information about services, resources, and eligibility.
- Conduct two to three demonstrations for improving access to housing services.
- Develop a direct care workers' guild.
- Develop a resource inventory for recreation services, replicate a monthly calendar of low-cost events, and develop a Universal Access Guidelines Tool Kit.
- Conduct two to three demonstrations for improving access to transportation services.
- Develop a detailed design for generic infrastructure to support integrating data across multiple departments and programs.

Abstract

Maine has already developed a good community services system with a wide array of community living supports. Quality Choices for Maine seeks to take this system to the next level, where consumers have more choice and control; where community-relevant quality management structures are built into Maine's community-based living options and incorporate consumer perspectives; where identified gaps are addressed (access to information, direct care workers, housing, transportation, and recreation); and where integrated interdepartmental data support interdepartmental collaboration.

The grant's focus is largely interdepartmental. It will be used to develop consistency across programs and the infrastructure for supporting a shared interdepartmental vision for serving persons with disabilities, as well as to address access barriers common to multiple population groups.

Quality Choice for Maine directly responds to and continues the work performed under Maine's Olmstead initiative, which has been a collaborative process involving representatives from five departments (Human Services, Behavioral and Developmental Services, Education, Labor, and Corrections) and a broad cross-section of consumer representatives.

MARYLAND

Grant Information

<i>Name of Grantee</i>	Department of Mental Health and Hygiene
<i>Title of Grant</i>	Increasing Access, Service Availability, and Quality in Maryland's Long-Term Care System
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$1,025,000

Contact Information

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Subcontractor(s)

To be determined by an RFP process in the first year of the grant.

Target Population(s)

People of all ages with disabilities. One grant initiative is designed specifically for children with serious emotional disturbances.

Goals

- Permanently increase the availability of attendant care services.
- Provide information and assistance to consumers in acute care hospitals to aid decision-making and assist with transitions back to the community.
- Assess the quality of community-based long-term care services and use that information to focus on quality improvement efforts in the future.
- Improve community-based service delivery to children with serious emotional disturbances.

Activities

- Develop a pilot project to provide outreach to persons in hospitals to inform them of community-based long-term care options to prevent unnecessary institutional placement. The project will include working with a hospital discharge planner to inform individuals of community-based services and programs at the point of discharge from the hospital. This initiative also includes funding for the development of educational materials to inform individuals about community-based programs in Maryland.
- Target efforts to increase the community long-term care workforce. This includes hosting provider job fairs across the state targeted to direct care workers where technical assistance with completion of the provider applications and specific qualifications can be provided.
- Develop a capitated demonstration program to better serve children with serious emotional disturbances (SED).
- Develop performance measures for community-based long-term care programs. This includes development and implementation of consumer satisfaction surveys for Maryland's community-based programs.

Abstract

The Real Choice Systems Change Grant will build on Maryland's commitment to providing home and community-based services to individuals in the community. The funding will enable Maryland to address a number of issues in delivering long-term care services. Maryland is in the process of developing a Consumer Advisory Board (CAB) that builds on the consumer workgroup established to develop the Real Choice Systems Change grant initiatives in the summer of 2001. The CAB will offer advice and recommendations in the process of the implementation of the grant initiatives. The CAB will work collaboratively with the other Maryland grant awardees.

The grant includes four initiatives:

1. Implementation of a pilot project to provide outreach and information to persons of all ages with disabilities in acute care hospitals to ensure that they have comprehensive information about community-based long-term care options and how to access them, particularly when planning for discharge from acute care settings.
2. Focus on implementing activities designed to attract and retain long-term care direct care workers and mitigate the long-term care worker shortage.
3. Development and implementation of a managed care demonstration program to provide coordinated long-term care services to children with SED who would otherwise likely "fall through the system cracks" and languish in long-term care facilities or psychiatric hospitals. Development and implementation oversight would be grant-funded. Services would be state-funded.
4. Development of quality indicators for long-term care services, a comprehensive satisfaction survey and survey approach to be administered to home and community waiver participants and establishment of a quality measurement and improvement process that would be maintained after the grant period concludes.

MASSACHUSETTS

Grant Information

<i>Name of Grantee</i>	Center for Health Policy and Research University of Massachusetts Medical School
<i>Title of Grant</i>	Massachusetts Real Choice Systems Change: Enhancing Community Based Services
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$1,025,000

Contact Information

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Subcontractor(s)

None at this time.

Target Population(s)

Individuals with disabilities and long-term illnesses.

Goals

- Improve coordination and collaboration among agencies in the development of long-term support systems' policy studies, program re-design options, and related pilot-testing activities.
- Plan for an integrated information infrastructure that will involve developing state-of-the-art tools for client functional assessments, streamlining the eligibility determination process for long-term care services, and enhancing service coordination options.
- Develop, implement, and evaluate new community-based service coordination and delivery system models.
- Develop meaningful and sustainable mechanisms for involving consumers in the planning and program development process.
- Develop systems for quality monitoring and continuous quality improvement of home and community-based long-term care services.

Activities

- Implement interagency policy coordination and program development.
- Assess existing functional assessment tools used by Massachusetts and by other states.
- Evaluate funding options for community-based long-term services.
- Integrate funding models.
- Use pilot programs for community-based long-term care delivery models.
- Integrate acute and long-term supports through coordinated care strategies.
- Implement early intervention and prevention for individuals at risk of functional decline and institutionalization.

Abstract

Partnerships. This proposal builds upon existing relationships and initiatives involving state agencies and disability advocacy and advisory groups. Leadership for activities under this grant will be provided by representatives from the Executive Office of Health and Human Services (EOHHS), the Division of Medical Assistance (DMA), and the Massachusetts Rehabilitation Commission (MRC), with support from the University of Massachusetts Medical School (UMMS).

Coordination of activities between the leadership team and the other key state agencies involved—the Departments of Mental Health (DMH), Mental Retardation (DMR), and Public Health (DPH), and the Executive Office of Elder Affairs (EOEA)—will be accomplished through an Interagency Steering Committee and a Working Group for Community Long-Term Care. Consumer input into policy evaluation and the design and implementation of infrastructure changes will be assured through a working partnership with the disability community and the establishment of a Consumer Task Force and integrated policy working groups that include representation from consumers, providers, and state agencies.

Outcomes. The primary outcomes of this grant will be sustainable improvements in the state infrastructure responsible for long-term care policy coordination and program implementation; a streamlined functional assessment, eligibility determination, and service coordination system; recommendations for standardized quality assurance measures/tools; and field-tested models of coordinated, culturally appropriate, community-based long-term care services that respect consumer preferences and needs.

MICHIGAN

Grant Information

<i>Name of Grantee</i>	Department of Community Health, Long Term Care Programs
<i>Title of Grant</i>	Michigan's Real Choice Systems Change Grant
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,000,000

Contact Information

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Subcontractor(s)

To be identified through RFP processes during the first year.

Target Population(s)

The first two initiatives target the general LTC population: working age adults with disabilities and elderly adults. The Consumer Cooperative Initiative targets individuals with developmental disabilities or mental illness within a pilot community.

Goals

The grant has three distinct components: the LTC Outcomes and Evaluation Systems Initiative, the Virtual Organization Initiative, and the Consumer Cooperative Initiative.

- LTC Outcomes and Evaluation Systems (OES).
 - Strengthen consumer/family input into the LTC OES.
 - Develop a model for vertically integrated OES across state and local agencies.
 - Improve outcomes through the use of quality indicators across LTC settings (nursing facilities, home care, and acute/primary care).
- Virtual Organization (VO) Initiative.
 - Use modern information technology and systems design to support an LTC delivery system that empowers consumers.
 - Provide consumers opportunities to use assistive technologies.
 - Use e-business technologies within system administration.
 - Obtain real-time feedback on satisfaction, cost/benefit analyses, and performance improvement efforts.

- Consumer Cooperative Initiative.
 - Develop organizational governance to ensure consumer control of the cooperative.
 - Establish process to ensure consumer control over access and management of services and supports.

Activities

- Include consumers on HCBS site monitoring teams.
- Select/develop quality indicators for use across LTC settings.
- Develop a method for assessing consumer satisfaction.
- Develop web based options for determining eligibility and accessing services.
- Develop practice guidelines for use of assistive technologies.
- Contract with a community mental health board to pilot the consumer cooperative model.
- Develop the organizational structure and operations for the cooperative.
- Conduct a participatory evaluation of the cooperative.

Abstract

The grant proposal builds upon Michigan's plan for developing an integrated LTC system, as described in the Michigan LTC Report and Recommendations. The LTC Outcomes and Evaluation System Initiative seeks to strengthen our quality assurance and improvement systems by expanding the roles of consumers and family members in system design, implementation, and evaluation; by developing outcomes and quality indicators for the continuum of services; by developing effective methods for assessing consumer satisfaction; and by supporting quality improvement initiatives in local agencies.

The Virtual Organization Initiative will develop a model for administering an integrated system of long-term care, in which access and service delivery are coordinated across primary/acute care, home and community-based services, and nursing facilities. The VO is a business model that allows consumers to use telephone or web technology to identify and arrange services, communicate needs and satisfaction with services, and allows providers to electronically link into a full service network to better serve customers.

The Consumer Cooperative Initiative will develop a model in which consumers and family members will collectively assume responsibility for their outcomes and take control of the resources needed to achieve them. The Co-op will allow members to design and obtain the services they prefer, with more creativity, responsiveness, and cost-effectiveness. This model offers an exciting advancement in systems changes in support of consumer-directed services.

MINNESOTA

Grant Information

<i>Name of Grantee</i>	Department of Human Services Continuing Care for Persons with Disabilities
<i>Title of Grant</i>	Pathways to Choice: Minnesota's System Change Initiative Grant
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,300,000

Contact Information

Karen Langenfeld, Project Team Leader	651-582-1941	karen.langenfeld@state.mn.us
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444 Lafayette Road
Saint Paul, MN 55155-3872

Subcontractor(s)

To be determined by an RFP process in the first year of the grant.

Target Population(s)

People with disabilities and chronic illnesses of all ages who are underserved such as people from communities of color, people who are low income, people with severe disabilities, and people from tribal nations.

Goals

- Develop a model for consumer-designed and driven quality assurance and improvement functions to be implemented within the long-term care delivery system in Minnesota.
- Assure that consumers have access to timely, consistent, accurate information that supports self-determination and informed choices.
- Consumer-driven quality assurance and improvement functions will be integrated into every aspect of the project to assure that frequent and accurate customer feedback and information are obtained and used effectively to correct or prevent problems as they are identified, and that quality improvement is assured.

Activities

- Recruit and convene a 15-member quality design commission comprising 51 percent primary consumers.
- Develop a model for consumer-driven quality assurance and quality improvement.
- Develop a model for information, referral, and assistance (IR&A) and create three regional IR&A networks to provide service to target populations.
- Develop training materials to be used for and with the IR&A networks.
- Develop an automated consumer feedback system to evaluate and measure consumer satisfaction with the service delivery system and consumer quality of life outcomes.

Abstract

Minnesota intends to create an exemplary delivery system of services for people of all ages with disabilities or long-term illnesses. The state has a comprehensive set of traditional, prescriptive services, and in recent years has built a partial patchwork of consumer-centered service options. To transform Minnesota's services array into a replication model for other states, a fundamental change in thinking is needed. Minnesota proposes a strategy that uses new sources of leadership, new forms of service organizations, and new methods of training to instill a consumer-centered philosophy throughout the system network. The strategy includes:

Quality assurance and improvement. The state will create a quality assurance and improvement model that is consumer designed, directed, and evaluated. A consumer quality commission will be an ongoing element and will provide continual design, direction, and evaluation of the other project strategies. This quality commission will be used to provide direction for many of DHS' quality assurance ideas.

Information, referral, and assistance. The state will develop a central information system with accurate and consistent information with outreach tailored to underserved populations. Features include updating the state's web site so that consumers, advocates, providers, and agencies receive the same information in a useful, easily understood manner; organizing county-level information networks with localized, detailed information and assistance; and initiating a 1-800 number system that ties together state and local information and connects people needing additional help with advocates and providers.

Since the grants have been awarded, DHS is moving forward with implementing a 211 system. The grants will be used to support this system. The grants will also be used to initiate some local networks to provide more intensive one-on-one assistance and advocacy efforts—in partnerships with counties, consumers, and private/public strategies.

MISSOURI

Grant Information

<i>Name of Grantee</i>	Department of Social Services
<i>Title of Grant</i>	Flexible Choices for Independence
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,000,000

Contact Information

Sherl Taylor, Medicaid Manager 573-751-9290 sherltaylor@mail.medicaid.state.mo
Division of Medical Services
615 Howerton Court; P.O. Box 6500
Jefferson City, MO 65102-6500

Subcontractor(s)

University of Missouri-Kansas City Dr. Christine Rinck 816-235-1760

Target Population(s)

Consumers of all ages who have a disability or long-term illness.

Goals

- Streamline the system to assure easy and quick access to needed services and supports.
- Assure that the infrastructure and process reflect consumer choice and consumer input.
- Foster interagency coordination and collaboration.
- Assure informed choices at all stages of care so that consumers can make good decisions about their lives.
- Enhance linkages at critical points to assure successful transitions to community living.
- Conduct research on small demonstration projects to identify best practices and projects that should be replicated.
- Establish a quality assurance mechanism that relies on consumer input and is data-driven.

Activities

- Develop resources for training on informed choices for a wide audience.
- Train consumers on how to discuss informed choice with other individuals with a disability or long-term illness.
- Identify perceptions of consumers, providers, service coordinators, and staff agency staff.
- Examine length of hospital stays and the number of persons transferred from hospitals to nursing homes, who stay longer than anticipated, and conduct a pilot that attempts to address each of the factors found in the study, to determine what strategies are most successful in facilitating living in community settings.
- Develop and pilot a quality assurance process that can be used for all participating agencies.
- Develop and pilot a standardized application process and referral system.

Abstract

The goal of Flexible Choices for Independence is to enhance the lives of people with a disability or long-term illness through systems change to allow them to live in the most integrated community setting, exercise meaningful choices about their lives, and obtain quality services.

The outcome of the activities of this grant will be that people with a disability or long-term illness will have a significant voice in choices about their life and be able to shape the services that they receive. In addition, services will be more consumer-driven and better serve people with a disability or long-term illness.

NEBRASKA

Grant Information

<i>Name of Grantee</i>	Nebraska Department of Health and Human Services Finance and Support
<i>Title of Grant</i>	Real Choice for Nebraskans
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,000,000

Contact Information

Mary Jo Iwan, Deputy Administrator Office of Aging and Disabilities 301 Centennial Mall S., 5 th Floor; P.O. Box 95044 Lincoln, NE 68509-5044	402-471-9345	maryjo.iwan@hhss.state.ne.us
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Subcontractor(s)

University of Nebraska Public Policy Center	Nancy Shank, MBA	402-472-5687
University of Nebraska Medical Center Munroe Meyer Institute	Barbara Jackson, Ph.D.	402-559-5765

Target Population(s)

Children and adults of all ages with physical disabilities, developmental disabilities, or behavioral health problems.

Goals

- Implement a consumer-directed model of services coordination and services delivery.
- Improve consumer access to, and information about, supports and services.
- Develop a system that allows consumers from various disability systems to access and receive needed services.
- Implement a quality management system that ensures the health and well-being of consumers through continuous consumer-directed monitoring and improvement.
- Make available to consumers and agencies a comprehensive, statewide resource database of health and human services.

Activities

- Gain consensus of consumer task force on choice definition, risk, and guiding principles for systems development.
- Market Real Choice philosophy to internal and external target audiences, and articulate what it means in practice.
- Analyze current services coordination across systems to determine steps needed to implement consumer-directed approach and transdisciplinary model.
- Set uniform standards, practices, and methods pertaining to collection, management, use, and promotion of data for resource directories across local and state agencies and organizations.

Abstract

Nebraska's current service delivery system comprises programs that provide services and supports through consumer-directed, as well as state-directed, philosophies and variations in between. Many of these programs operate in isolation from one another, even though consumers often need services across programs. Consumers and policymakers have become aware of, and are advocating for, system-wide adoption of a consumer-directed philosophy.

Nebraska is struggling with the challenge of moving from an inspection and certification-based philosophy to one that gives consumers more responsibility in monitoring and quality assurance. In the realm of consumer-directed services, the state's process of identifying, approving, and monitoring providers must be revisited to ensure that consumers have real choices, are provided with full disclosure, and are provided necessary safeguards. For consumers to have real choices, consumers need to have easy, consistent, and timely access to information on available programs, resources, and services.

Nebraska proposes to implement a consumer-directed philosophy across populations—children and adults of all ages with physical disabilities, developmental disabilities, or behavioral health problems—with consumer choice and risk defined and incorporated into services, delivery, regulations, quality assurance, and practices. Consumers, agency, and program staff, will collaborate to design and implement effective and enduring improvements in a culturally competent community long-term service and support system. They will also collaborate to identify quality measures and to design and implement a sustainable quality management system to monitor the efficiency of services in achieving the client outcomes desired and the delivery of services in a manner that meets consumers' expectations and preferences.

Consumers, services coordinators, providers, and other stakeholders participating in long-term support systems will have needed information about services and supports at the right time to effectively make informed choices regarding services that are appropriate, effective, and user responsive through improved access to long-term support systems.

Through consumer role enhancement, skill building, training, and support, consumers will have the necessary skills, knowledge, and supports to successfully live in the most integrated community settings chosen; exercise meaningful choices; and obtain quality services.

Services coordinators across programs will embrace a consumer-directed philosophy and have the necessary knowledge and skills to effectively support consumers, exercising meaningful choices in obtaining quality services through services coordination role redefinition, skill building, training, and support.

NEW HAMPSHIRE

Grant Information

<i>Name of Grantee</i>	Department of Health and Human Services
<i>Title of Grant</i>	Facilitating Lifespan Excellence (FLEX)
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,300,000

Contact Information

Lee Bezanson Associate Director of Health Planning and Medicaid 129 Pleasant Street Concord, NH 03301	603-271-4348	lbezanso@dhhs.state.nh.us
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Subcontractor(s)

University of New Hampshire Institute on Disability	Jan Nisbet Mary Schuh	603-228-2084
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Target Population(s)

All persons with disabilities.

Goals

- Fill identified gaps and address identified weaknesses in the current long-term support system.
- Identify barriers to real choice and consumer-directed services and recommend reforms.
- Develop educational and technical assistance activities and strategies for implementing consumer-directed services.
- Develop a comprehensive evaluation strategy that uses both empowerment evaluation methods and summative evaluation methods within and across all project components.
- Develop creative dissemination strategies designed to support change and empower consumers.

Activities

- Develop and support management and advisory structures that support completion of project objectives and partnerships with other state initiatives for permanent systems change.
- Implement, using an RFP process, specific model projects that will develop solutions to barriers to consumer choice and integrated community living.
- Implement a mentorship pilot project for persons with developmental disabilities.
- Implement a mobile unit to bring assistive technology and durable medical equipment to citizens in their homes and communities.
- Develop a Policy Resource Center to identify and analyze barriers to consumer-directed services and to make recommendations for actions to reduce or eliminate these barriers.
- Establish a community laboratory to implement projects to improve community long-term care systems.
- Provide peer supports to persons with mental illness.

Abstract

Governor Jeanne Shaheen, with support and leadership from the New Hampshire Department of Health and Human Services, Granite State Independent Living, the University of New Hampshire Institute on Disability, Franklin Pierce Law Center, numerous consumer groups, and other stakeholders proposes to “improve health and long term care service systems and supports for people with disabilities and long-term illness to live in the community.”

This proposal, developed collaboratively by the disability and aging communities, is designed to create and implement improvements in community long-term care systems. Several specific projects are proposed, each of which is designed to fill an identified gap or weakness in the current infrastructure of long-term supports. These projects will then be implemented in one model community or region that will serve as a laboratory for change.

In addition we will develop a policy center to review all laws and regulations that create barriers to full community integration and to make recommendations for change. The Policy Center will also provide education and training to the public, legislators, providers, and advocates. The project will be led by a consumer advisory council that has broad cross-disability representation across all age spans.

NEW JERSEY

Grant Information

<i>Name of Grantee</i>	New Jersey Department of Human Services
<i>Title of Grant</i>	New Jersey Real Choice Systems Change Project
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,000,000

Contact Information

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www.state.nj.us/humanservices/dds

Subcontractor(s)

None selected to date.

Target Population(s)

Multiple populations of persons with disabilities, including elderly persons, persons with developmental disabilities, people with serious mental illness, children with disabilities, and people with adult-onset disabilities. Residents at the state's developmental centers, psychiatric hospitals, and nursing facilities are the initial priority populations as we redesign and enhance our long-term care system to increase community options.

Goals

- Expand community-based services and supports to be offered as an alternative to institutional placements.
- Increase the use of consumer-directed service models throughout the long-term care system.
- Increase the stock of affordable, accessible housing for people with disabilities.
- Increase the availability of personal care assistant (PCA) workers and offer a back-up system of emergency PCA services.
- Develop and pilot an objective assessment for consumers with developmental disabilities and a process to involve consumers in the decision making for long-term care services.

Activities

- Create an interactive housing web site for use by persons of all ages with disabilities.
- Hold a statewide housing summit to showcase innovative practices and to stimulate creative planning for future housing options.
- Provide “seed money” for innovative housing projects through a competitive RFP process.
- Develop and pilot a personal care assistant (PCA) registry and rapid response PCA back-up system.
- Develop an educational program for case managers and other front line staff on the benefits of consumer-directed service models.
- Develop a set of quality measures for community-based and consumer-directed services.
- Conduct an evaluation of New Jersey’s systems change efforts resulting from the grant.

Abstract

New Jersey’s Real Choice System Change Grant is designed to make enduring changes in our system of long-term care for people of all ages, with a wide variety of disabling conditions. Through a series of pilot programs and contracts, we will seek to address issues related to access, quality, adequacy, availability, and responsiveness of our system of community-based care. The grant activities build on current ongoing state efforts and seek to deal with gaps in service and areas of weakness identified by our Olmstead Stakeholder Task Force.

In addition to the activities and projects identified above, New Jersey will be working on a variety of infrastructure improvements, including working with the State Board of Nursing on increasing delegation to paraprofessional workers, and reviewing 1915(c) home and community-based waivers to determine where improvements or enhancements may be needed. New Jersey will also develop a transition curriculum on consumer direction for secondary school students with disabilities; conduct a “needs assessment” in the area of accessible, affordable housing; and do further work on front line staff recruitment and retention.

The Real Choice Systems Change Grant efforts will be monitored and guided by an Advisory Council composed of consumers, family members, advocates, providers, and government agency representatives. Consumer involvement throughout the project is seen as critical and essential to its success. A program manger will be hired to help make sure that all contracts are carefully monitored, all deliverables received, and that the project stays on track.

The anticipated benefit of undertaking these grant-funded activities is an improved and effective system of long-term community supports and services that provides maximum flexibility and choice to persons with disabilities in New Jersey.

NORTH CAROLINA

Grant Information

<i>Name of Grantee</i>	NC Department of Health and Human Services
<i>Title of Grant</i>	Direct Care Workforce Recruitment and Retention
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$1,600,000

Contact Information

Lynda McDaniel, Assistant Secretary 919-733-4534 lynda.mcdaniel@ncmail.net
Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001

Subcontractor(s)

Institute on Aging UNC at Chapel Hill	Bob Konrad <i>(will assist with data analysis)</i>	919-966-2501
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Target Population(s)

All populations needing home and community-based services.

Goals

- Reduce institutional bias in the state's long-term care system.
- Improve the size, stability, and quality of the state's direct care workforce to address the current workforce crisis, and expand this workforce to better meet the personal care and home management needs of persons with disabilities now and in the future.

Activities

- Design and implement a consumer-directed care model.
- Develop new competency-based job categories to provide a career ladder for direct care workers in home and community-based settings.
- Develop educational and marketing materials for use with the media, the general public, schools, and nontraditional populations, etc., to promote employment opportunities and enhance the image of, and appreciation for, direct care workers.
- Compile annual turnover data from home care agencies and assisted living facilities, using a uniform methodology to track the workforce over time.
- Collect, compile, analyze, and disseminate data specific to North Carolina's direct care workforce.

Abstract

Grant activities will focus on several major areas: reducing institutional bias, developing a career ladder for direct care workers, implementing public education and awareness efforts to promote recruitment and retention of direct care workers, and designing a consumer-directed care model and related accountability requirements, reimbursement policies, and policies covering fiscal intermediaries for clients.

Addressing direct care workforce issues will require a multi-pronged approach. First, we will examine options for increasing the availability and affordability of health care insurance coverage for direct care workers, as well as other benefits, including flexible work schedules, child and eldercare, and participation in retirement and other benefit plans.

To retain direct care workers, a career ladder is needed. Our project will develop competency-based training models with related wage recommendations that recognize incremental development of specialized competencies (e.g., working with persons with complex medical needs, developmental disabilities, dementia and other cognitive impairments; and development of mentoring skills, supervisory skills, effective communication skills, etc.). We will also perform a classification analysis of current state job categories for direct care workers and recommend any changes needed and payment levels based on competency level of worker. Finally, we will develop curricula, in-service, and continuing education programs in support of core and specialized training (including supervisory training and mentoring) and develop appropriate training outlets, opportunities for web based training, etc.

To recruit and retain direct care workers, it is necessary to enhance the image of this workforce. We will implement a range of public education and awareness efforts to promote information about direct care worker opportunities (paid and volunteer) focused on home and community care. These efforts will include the development of promotional and training materials for use in high school allied health programs. We will also convene a Task Force of direct care staff to get input on recruitment, retention, and marketing efforts, developing public service announcements, video spots, feature articles, flyers for use with the media, general public, high schools, Hispanic and non-traditional populations, disabled population, Job Corps, etc.; and conduct job fairs to address the image and importance of this workforce. Additionally, we will promote the development of a direct care worker association in the state, and compile and disseminate information about innovative strategies being used to address recruit and retain direct care workers.

We will also collect and analyze data about the direct care workforce that will inform our efforts to recruit and retain workers.

OREGON

Grant Information

<i>Name of Grantee</i>	Oregon Department of Human Services
<i>Title of Grant</i>	Advancing Consumer Direction Through Enhanced Infrastructure
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,000,996

Contact Information

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Subcontractor(s)

Subcontracting process is not yet completed.

Target Population(s)

Adults and children with disabilities, with a particular focus on persons with psychiatric disabilities for several initiatives (e.g., person-centered planning, development of a pilot brokerage, increasing residential capacity).

Goals

- Increase affordable, accessible housing.
- Promote informed choice and consumer self-determination.
- Provide training to consumers and family representatives, service coordinators and service providers.
- Increase the availability of personal assistants and contract registered nurses (CRNs).

Activities

- Provide local assistance to consumers and other stakeholders in planning for needed housing; leveraging resources, developing partnerships; and providing funds for deposits, furnishings, and rent subsidies.
- Revise the planning used by the mental health system to a person-centered process promoting consumer choice, self-determination, and community integration.
- Provide funding to add and strengthen consumer-run drop-in centers throughout Oregon.
- Provide training to consumers concerning the ADA, the Olmstead decision, self-advocacy, assessing care needs, protection from abuse, and self-directing care.
- Develop a statewide recruitment effort for personal assistants.

Abstract

The *Advancing Consumer Direction Through Enhanced Infrastructure* grant is intended to refocus and reorient people with disabilities and the workforce towards the outcome of maximizing consumer self-determination. A grant coordinator and two housing staff will coordinate the efforts of four main workgroups composed of consumers, family representatives, stakeholders, and agency staff in implementing 24 specific goals identified in the grant.

The grant will pilot a consumer-run brokerage in one Oregon County and assist in the development and strengthening of drop-in centers demonstrating new models of consumer-directed choice. Cross-disability and cross-discipline events and conferences conducted during the grant period will foster new partnerships and service integration. Many educational and training activities are planned to change service provider culture across the range of services to adopt consumer-directed approaches, to enhance the skills of the personal assistance workforce, and to increase the number of nurses trained to support persons with disabilities living in the community.

SOUTH CAROLINA

Grant Information

<i>Name of Grantee</i>	Department of Health and Human Services
<i>Title of Grant</i>	Options for Community Living
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$2,300,000

Contact Information

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Subcontractor(s)

University of South Carolina School of Medicine	Kathy Mayfield-Smith	803-898-4564
University of South Carolina School of Public Health	Thomas E. Brown, Ph.D.	803-777-5337

Target Population(s)

SC Access targets persons of all ages with a disability or long-term illness, their families, and caregivers. SC Choice targets elderly and disabled HCB waiver beneficiaries (i.e., seniors and working age adults with physical disabilities), adults with mental illness, and children with severe emotional disabilities in two geographic regions of the state.

Goals

- Improve accessibility to comprehensive, up-to-date information about services and resources in the community for older adults and persons of all ages with disabilities.
- Increase options for consumer-directed care.

Activities

- Develop software to support web based information and referral (I&R) system.
- Collect statewide data for I&R resource directory.
- Make necessary changes in policies and procedures to afford increased consumer choice and control in services across three agencies.
- Implement two pilot sites to test new I&R system and consumer-directed models.

Abstract

The SC Department of Health and Human Services (SCDHHS) is partnering with the SC Department of Mental Health and the Continuum of Care for Children to develop a project known as *Options for Community Living*.

There are two components under the *Options for Community Living* grant: *SC Access* and *SC Choice*. *SC Access* will develop, implement, and maintain a database of comprehensive information and assistance services for children and adults of any age with a disability, long-term illness or need. *Access* will be housed at the South Carolina Department of Health & Human Services and will be available online in real time at local, regional, and state levels to agencies and organizations serving persons with disabilities, including the Aging Network, Medicaid waiver programs, disability agencies, and consumer and advocacy groups.

SC Choice will create the infrastructure to support more consumer-directed services, including the development of support coordination, fiscal intermediaries, and the use of cash equivalencies. This program will be piloted in two areas of the state, across disability groups, and will enable the consumer, in consultation with a support coordinator, to perform many of the duties currently performed by a case manager.

State and local advisory committees will assist with the design and implementation of *SC Access* and *SC Choice*, including the development of consumer satisfaction measures.

TENNESSEE

Grant Information

<i>Name of Grantee</i>	Department of Mental Health & Developmental Disabilities
<i>Title of Grant</i>	Housing within Reach
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$1,768,604

Contact Information

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Subcontractor(s)

Foundations Associate	Michael Cartwright Tom Doub, Ph.D.	615-256-9002 615-256-9002
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Target Population(s)

Individuals with mental illness who are currently in need of permanent, safe, affordable, quality housing and support service options.

Goals

- Design and implement a more effective, consumer-directed and accessible housing resource system for persons with mental illness.
- Reduce the stigma of mental illness, thereby providing a more welcome environment for these residents in community neighborhoods.

Activities

- Hire four consumer housing specialists in targeted communities (Chattanooga, Jackson, Memphis, and Nashville).
- Develop and maintain a housing resource web site that is accessible statewide and, specifically, through hardware installed in drop-in centers in targeted communities.
- Facilitate annual week-long housing academy and multiple semi-annual housing summits.
- Develop a statewide anti-stigma media campaign and television commercial spots.
- Conduct a research initiative to evaluate efforts to meet the housing needs of consumers.
- If sufficient funds are available, provide for a statewide housing hotline.

Abstract

This project will make a long-term change in housing and support services access for people diagnosed with serious and persistent mental illness. All too often these individuals are ostracized, stigmatized, and left to fend for themselves—unwelcome within the communities in which they live. Key project goals include designing and implementing a more effective, consumer-directed, and accessible housing resource system for people with mental illness; increasing the number of persons in quality, affordable housing; and reducing the stigma of mental illness statewide.

Project goals will be addressed through multifaceted activities, including employment of four consumer housing specialists in targeted communities; the development of a housing resource web site accessible throughout the state; hardware strategically installed at key community drop-in centers to promote access to the web site; facilitation of an annual weeklong housing academy and biannual housing summits; formation of a statewide housing hotline; development of a high-quality anti-stigma mass media campaign, and a research initiative to evaluate efforts of meeting the needs of consumers as they transition to community-based housing and supports.

These activities will result in an enduring change to the state's current mental health housing system by increasing the availability and accessibility of housing resources for consumers and providers; increasing consumer involvement in housing development and their choice in housing decisions; increasing opportunities to live in the most integrated and preferred community setting; and changing community attitudes to decrease stigma and create a more welcoming environment. The grant funds will be supplemented by additional in-kind funding of over \$400,000. This modest investment will produce a sustainable change in available community supports that enable individuals with mental illness to live and participate fully in their communities.

Activities

- Assess current information and referral system. Identify gaps and deficiencies and identify measures to improve access to information and assistance.
- Develop training materials and provide statewide and local training, and develop ongoing capacity by recruiting a pool of self-advocates and family members.
- Implement a counseling program to discuss placement options to ensure that consumers applying for admission to a nursing home are informed about all their available options.
- Establish a paraprofessional organization.
- Amend 1115 Waiver.
- Research and propose necessary legislative and regulatory changes to permit direct consumer funding.

Abstract

Vermont's Department of Aging and Disabilities, Division of Developmental Disabilities, and the Division of Mental Health will work collaboratively to increase community integration, real choice and control for elders, younger adults with physical disabilities, people with developmental disabilities and their families, and adults with severe mental illness.

The three systems that are partners in this Real Choice proposal have evolved separately and differ in the amount of community integration, choice, and control offered to the populations they serve. Consumers continue to experience lack of choice and control over their service options.

The goals of the Real Choice Systems Change Project are to effect enduring systems that:

- promote continued progress toward community integration of services, and
- promote real choice about how, where, and by whom services and supports are delivered.

The project objectives are to:

- provide consumers with the tools to exercise real choice—good information, technical assistance, and advocacy skills;
- increase access to home and community-based services for persons of all ages with physical disabilities; and
- increase consumer control through a direct consumer funding option for those receiving developmental services.

To address the identified problems, the project will undertake activities to:

- create an accessible cross-age and disability system to provide information and assistance;
- provide self-advocacy skills to consumers and families, and training for providers to promote facilitation of consumer self-advocacy;
- create a stable, valued, appropriately trained and compensated workforce by developing a paraprofessional association and implementation of other recommendations;
- expand the 1115 waiver to eliminate the institutional bias and create equal access to home and community-based care; and
- create a pilot that can be replicated statewide for direct consumer funding for developmental services.

VIRGINIA

Grant Information

<i>Name of Grantee</i>	Department of Medical Assistance Services Long Term Care & Quality Assurance
<i>Title of Grant</i>	Consumer Choices for Independence
<i>Type of Grant</i>	Real Choice Systems Change
<i>Amount of Grant FY 2001</i>	\$1,025,000

Contact Information

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Subcontractor(s)

Virginia Institute for Developmental Disabilities	Dr. Fred Orelove, Director	804-828-3908
Virginia Tech Center for Gerontology	Dr. Karen Roberto, Director	540-231-7657

Target Population(s)

Beneficiaries of Virginia's home and community-based services waivers, and their families and caregivers.

Goals

- Ensure that individuals and their families and caregivers may realize full and meaningful participation, choice, and control of needed supports through Virginia's Medicaid waivers:
 - through development of a paperless assessment process;
 - by providing the right information at the right time to individuals and their caregivers so they can make key life decisions, manage their services, and manage their conditions or disabilities for the most positive outcomes possible;
 - through the implementation of consumer-directed services as included in Virginia's waivers; and
 - by addressing gaps in quality assurance and satisfaction for community-based waiver services through the development of performance, outcomes, and satisfaction measures for continuous quality improvement and use.

Activities

- Develop a paperless assessment process for people who request admission to Virginia’s Medicaid waivers.
- Ensure the ability of beneficiaries and families to make informed choices about home and community based services by providing:
 - a “RoadMap” to services offered by the Commonwealth to promote “one stop shopping” for information;
 - an interactive web site that will allow individuals and caregivers to search for resources and information across life spans, disabilities, diagnoses, desired outcomes, and geographic locations; and
 - an introductory video that provides an overview of available resources, supports, and services. To the extent possible, persons with disabilities will be hired to develop and be featured in the video.
- Provide training on consumer-directed services as included in Virginia’s waivers. This will be accomplished through an agreement with the Virginia Institute for Developmental Disabilities (VIDD) at Virginia Commonwealth University.
- Develop performance, outcomes, and satisfaction measures for continuous quality improvement and use. This will be accomplished through an agreement with the Center for Gerontology at Virginia Tech.

Abstract

Virginians of all ages with disabilities and long-term illnesses have, in multiple forums, related their hopes and dreams to become active participants in communities and to exercise greater choice and control over the decisions that have an impact on their lives. When the Consumer Task Force met to discuss an application for a Real Choice Systems Change Grant, waiver consumers once again stated their desire to have supports available to live, work, go to school, play, grow old in their own neighborhoods, and to be instrumental in the design of those supports. The Department of Medical Assistance Services (DMAS), in coordination with a Consumer Task Force, and a wide range of agencies and organizations, developed the Grant application to create enduring and effective improvements to Home and Community Based Services (HCBS) in Virginia.

Successful project implementation will lead to increased ease of access to services available through waivers, methods for informing consumers about choices and options for support, greater understanding and use of consumer-directed services, and increased consumer satisfaction with, and quality of, services.

DMAS will work with affected individuals and their caregivers and partner with individuals within the disability community as well as with the Virginia Institute for Developmental Disabilities at Virginia Commonwealth University and the Center for Gerontology at Virginia Tech to accomplish the above goals. The grant activities will be coordinated through a steering committee made up of state agencies and members of the advisory task force. A consumer task force of individuals and their caregivers and providers will provide direction throughout the 3 years of the grant activities.