Gateway to Community Living

State of Alabama
Long Term Care
Rebalancing Initiatives

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ROBERT BENTLEY
Governor

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R. BOB MULLINS, JR., MD
Commissioner

The Honorable Robert Bentley
Governor of the State of Alabama
Alabama State Capitol
Montgomery, AL 36130

Dear Governor Bentley,

It has been nearly 13 years since a landmark U.S. Supreme Court ruling (*Olmstead v. L.C.*) calling for provisions to be made for a disabled person to live a more normal and comfortable life in their community, instead of being institutionalized. During that time, the State of Alabama has continued to make significant strides in expanding home and community-based services and supports, as well as, enabling flexibility in the provision of home and community-based services.

Alabama Medicaid Agency has served as the lead state agency in developing and implementing procedures for compliance with the Court's decision, as directed by the Centers for Medicare and Medicaid.

Alabama Medicaid, in a cooperative effort with Alabama Department of Human Resources, Alabama Department of Mental Health, Alabama Department of Public Health, Alabama Department of Rehabilitation Services, and Alabama Department of Senior Services, has made a steadfast commitment to achieving a cost-effective system of supports that enables Alabamians with disabilities the opportunity to live and work in the most integrated setting available.

Although there is still much work to be done, achievements thus far are indicative of the progress the State has made in providing an option between institutional and home and community-based care through sound and concrete steps.

We are honored and proud to present "Gateways to Community Living," outlining the details of our long term care rebalancing initiatives that has helped improve the quality of life for so many of Alabama's disabled persons.

Sincerely,

R. Bob Mullins, Jr.

Alabama Medicaid Commissioner

The State of Alabama
Long Term Care Rebalancing Initiatives

Gateways to Community Living

Overview:

On June 22, 1999, the U.S. Supreme Court affirmed the policy by ruling in *Olmstead v. L.C.* that under the Americans with Disabilities Act (ADA) unjustifiable institutionalization of a person with a disability who, with proper support, can live in the community is discrimination. In its ruling, the Court said that institutionalization severely limits the person's ability to interact with family and friends, to work and to make a life for him or herself.

The Olmstead case was brought by two women in Georgia whose disabilities include mental retardation and mental illness. At the time the suit was filed, both plaintiffs were receiving mental health services in state-run institutions, despite the fact that their treatment professionals believed they could be appropriately served in a community-based setting.

The Court did not prescribe specific criteria for states to demonstrate compliance with the decision. Instead, it suggested that states develop a "comprehensive, effectively working plan" for its implementation. Following the Court's decision, the Centers for Medicare and Medicaid Services (CMS) instructed all state Medicaid agencies to begin development of such a plan. To complement the efforts of the states, over the past few years, the Department of Health and Human Services (HHS) has focused on expanding and promoting home and community-based services, offering support and technical assistance to states by providing flexible options through the Medicaid program.

In the State of Alabama, the Alabama Medicaid Agency (AMA) served as the lead state agency for the development and implementation of the plan.

The following ***Executive Summary*** outlines the evolution of Alabama's Long Term Care Rebalancing Initiatives. Furthermore, this summary depicts the foundational steps that were necessary for the State to achieve the progress that has been made thus far.

The Executive Summary
Initial Steps

Over the past several years, the State of Alabama embarked on efforts to plan for, develop, and implement services for people with disabilities and senior citizens, as a part of what was named the *Olmstead* Plan. The Olmstead Core Workgroup drafted a unifying theme as a title for the *Olmstead* Plan, designed to catch the imagination of the state's citizenry and policymakers: ***Sweet Home Alabama*: Under Construction.** It was an apt metaphor for the work necessary to establish a cohesive system of supports built upon the concepts of community, choice, and consumer direction. The architects of the proposed systems changes were its stakeholders, with special emphasis on the substantial and meaningful participation of people with disabilities and family members.

The *Olmstead* decision presented the State with an important opportunity to affect significant change in the way disability and aging services were planned, implemented, and funded at the state level and on the quality of life of all Alabamians. All Alabamians have been affected by the actions taken in response to this plan. Disability and long-term illness are not rare. They touch all of our families and our communities.

The *Olmstead* Building Process

Architects

An *Olmstead* Core Workgroup was appointed with more than 40 members, including substantial representation of people with various types of disabilities and long-term illnesses and senior citizens, their families, state agency representatives, service providers and advocacy groups. Four subcommittees of the Core Workgroup were formed to organize the large task ahead. These subcommittees were (1) Needs Assessment; (2) Best Practices; (3) Finance; and, (4) Consumer Advisory.

The *Olmstead* Planning Process

A series of focus groups were held in 2001 as a kick-off to the planning process. These meetings were held in six regions of the state— in both rural and urban Alabama. The focus group meetings were designed to promote feedback and consumer input in areas that were important to consumers and their families. Participants repeatedly expressed their concerns related to consumer involvement and flexibility in the provision of community services. Primary caregivers expressed the need for public awareness of the available resources and the need for more respite services. In all areas of the state, the participants were concerned about current state funding and future funding for the implementation of the *Olmstead* Plan.

Cornerstones: Principles and Recommendations

The Consumer Advisory Subcommittee took the lead in developing a set of principles to guide the work of all the others, ensuring that our efforts would be responsive to the needs of those who would be most affected. These principles were the cornerstones for building our dream home.

After a lengthy planning process, the workgroups developed a series of recommendations designed to both achieve compliance with the *Olmstead* court order and to improve the quality of life and quality of services and supports for persons with disabilities. These recommendations included:

- Promote Inclusive Communities
- Streamline Access and Coordination of Services
- Limited Resources for Expanding Availability of Community Supports and Services

The Foundation

In order to have an *Olmstead* Plan that could be successfully implemented, alternatives to institutional care would have to be widely available. In addition to state-funded services, Alabama provides a spectrum of home and community-based services through Medicaid State plan services and home and community based waivers.

Early Successes

Ticket to Work/Medicaid Infrastructure Grant

The *Olmstead* Planning Initiative fueled other opportunities within the State of Alabama that had already begun to address the recommendations described above. The State was awarded $625,000 through the Ticket to Work/Medicaid Infrastructure Grant in January 29, 2002, for an effective date January 1, 2002 through March 31, 2003. Annual continuation grants of $500,000 each were also received. A collaborative effort continues between Medicaid and the Alabama Department of Rehabilitation Services. The grant allowed the State of Alabama to assist individuals with disabilities to secure and maintain competitive employment through the provision of the Personal Assistance Service.

Personal Assistance Service is a range of services provided by one or more persons designed to assist an individual with a disability to perform daily activities on and off the job. Such services are designed to increase the individual's independence and ability to perform every day activities on and off the job.

Other provisions of the Ticket to Work/Medicaid Infrastructure Grant:

- Consumer-Based Policy Consortium to bring key stakeholders together to assess, review, and recommend policies and procedures to enhance employment supports for Alabama's citizens with disabilities
- Requests for Proposal for a Medicaid Buy-In Feasibility Study and evaluation of the Medicaid Infrastructure Grant
- Establishment of contract with a vendor for Case Management Redesign and Training
- Establishment of contract with a vendor to develop and pilot a training module for personal assistance service utilization for the consumer
- Establishment of contract with a vendor to conduct Personal Assistance Service provider training and develop an attendant registry for consumer use
- Development of an Outreach, Information, and Dissemination Learning Plan

Real Choice Systems Change Grant

Medicaid also received $2,000,000 in federal funds to implement the Real Choice Systems Change Grant during the effective dates of September 28, 2001 through March 27, 2005. Our proposal was developed in conjunction with the State's *Olmstead* planning process. The proposed grant activities were additional building blocks targeted to achieve enduring systems change in three areas: access, consumer choice/control, and expanded resources for home and community-based services. These building blocks assisted in assuring the success of the *Olmstead* Planning Initiative.

Other provisions of the Real Choice Systems Change Grant:

- Establishment of a Long Term Care Outreach and Education Unit within the Long Term Care Division to provide education and training to consumers, advocates, and providers on long term care initiatives.
- Establishment of a Disability/Aging Policy Advisory Group, a consumer-based group within the Long Term Care Division. The group's mission was to develop and formalize mechanisms for ongoing consumer input and enhanced coordination of services for the elderly and disabled.
- Conducting a study on the feasibility of a single point of entry system within the State. The system would be a streamlined process for consumers to access needed services, application procedures, eligibility determination, and other processes that could be accomplished at a single point.
- The Alabama Department of Senior Services (ADSS) revised the existing assessment tool used for waiver clients to ensure that the tool was more client-centered and that it incorporated the cognitive, social, and spiritual needs of the consumer.
- The Alabama Department of Mental Health and Mental Retardation opened the Office of Consumer Empowerment allowing for the development of a Grassroots Advocacy Committee of consumers to voice their concerns.
- The Volunteer and Information Center would maintain an information and referral clearinghouse through the 211 Connects call center.

In addition to the Real Choice Systems Change Grant awarded to Medicaid, the State was also awarded two nursing facility transition grants. The first was awarded to the Birmingham Independent Living Center (BILC) and the second was awarded to the ADSS.

Personal Choices—A Consumer-Directed Option

The ADSS, in partnership with the Alabama Medicaid Agency and the Alabama Department of Rehabilitation Services, was awarded grant funding from the Robert Wood Johnson Foundation to implement a pilot program of consumer-directed services for individuals currently enrolled in three Alabama home and community-based waivers. The following are the 1915(c) Home and Community-Based Waiver Services to be self-directed:

- Elderly and Disabled Waiver— Personal Care, Homemaker, Unskilled Respite, and Companion
- State of Alabama Independent Living Waiver—Personal Care and Personal Assistance
- Alabama Community Transition Waiver—Personal Care, Homemaker, Unskilled Respite and Companion

The targeted geographic areas for Medicaid-eligible beneficiaries from the Elderly and Disabled Waiver are Baldwin, Bibb, Escambia, Fayette, Greene, Hale, Lamar, Mobile, Pickens, and Tuscaloosa Counties.

The targeted geographic areas for Medicaid-eligible beneficiaries from the State of Alabama Independent Living Waiver are Bibb, Fayette, Greene, Hale, Lamar, Pickens, and Tuscaloosa Counties.

The targeted population for statewide self-directed personal assistance services is for participants enrolled in the Alabama Community Transition Waiver.

To implement this pilot project, the Alabama Medicaid Agency requested approval from CMS to add a consumer-directed option in the Medicaid State Plan. Alabama was the first state approved to add consumer-directed care options to the Medicaid State Plan under Section 1915(j). The program, *Personal Choices,* is an option for individuals in the pilot counties who are participants of the EDW and SAIL waiver.

Under the *Personal Choices* program, individuals are provided a monthly allowance from which they will determine what services they need. Participants may choose to hire someone to help with their care or they may wish to save money for equipment purchases. In the past, waiver participants were required to choose personal caregivers from a list of approved providers.

Long Term Care Choices Workgroup

The *Long Term Care Choices Workgroup*, hosted by the Alabama Medicaid Agency explored potential opportunities that may be available to the state as a result of recent federal initiatives to support elderly and disabled Medicaid recipients who wish to live in the community rather than institutions. The workgroup was comprised of approximately 35 individuals representing state agencies, advocacy organizations, provider associations and other interested stakeholders.

The *Long Term Care Choices Workgroup* was instrumental in the implementation of transitional case management activities for Medicaid recipients in institutions who desire to return to the community. Through this Workgroup transitional case management was an option available in the SAIL and HIV/AIDS waivers.

Long Term Care Partnership Program:

A movement at the federal level led to long term care partnership programs which were piloted in four states. In our state, the Alabama Long Term-Care Insurance Partnership Program, collaboration between the Alabama Medicaid Agency and the Alabama Department of Insurance, allows Medicaid to disregard, or exclude, the benefits paid under an approved policy when determining an applicant's financial eligibility for long-term care.

The amount excluded by Medicaid is on a dollar-for-dollar basis. For example, if a Partnership Policy pays a nursing home or other long-term facility a total of $54,000 on behalf of a resident, then that amount will be excluded from Medicaid's calculation of assets when that person applies for Medicaid coverage. The Partnership Policy also protects these assets from any subsequent Medicaid liens and recoveries.

State Progress
Long Term Care Rebalancing

In the 2009 Legislative Session of the State of Alabama, Senate Joint Resolution 84 (SJR 84) created the Long Term Care Rebalancing Advisory Committee. The overall purpose of this Committee is to develop a vision for a better, more responsive long-term care system and the policies to promote the new system.

The Resolution called for five subcommittees with specific charges:

- **Needs Assessment and Services**—charged with gathering information from consumers on the kinds of services they feel are needed that will divert or delay institutionalization and preserve or improve their quality of life.
- **Resource Development and Coordination**—charged with identifying the available services and resources within the State and presenting recommendations and approaches to providing services that are necessary to delay or divert institutionalization.
- **Single Point of Entry (SPE)**—charged with determining if a SPE is beneficial for consumers and families, and determining how the SPE should work within the State of Alabama.
- **Economic Impact**—charged with determining the financial impact of rebalancing Alabama's long-term care systems and making recommendations for the efficient use of available dollars.
- **Legislative Matters**—charged with determining what steps are needed politically to facilitate long-term care policy changes within the State of Alabama.

Each subcommittee selected a Chairperson to facilitate the flow of the meetings and ensure that the subcommittee remained focused on its specific charge. A recorder was selected to ensure that the discussions and activities of the subcommittee meetings were documented and that individual assignments and reach activities were documented and tracked. The Medicaid Agency assigned a staff person to support each subcommittee by providing Medicaid data, conducting research, and providing education on Medicaid services and other state supports.

The interest and involvement of the entire Long Term Care Rebalancing Advisory Committee were overwhelming. Many members participated on several subcommittees. Other members, who could not attend the meetings, followed the activities of multiple subcommittees.

The *Report of the Long Term Care Rebalancing Advisory Committee* was approved March 31, 2010, and was submitted to the Governor and the State of Alabama Legislative Body.

The Report was submitted as a first step toward the appropriate rebalancing of the long-term care system in Alabama. Future steps must take into account the quality of care and ability of consumers to direct their care while considering the interaction with existing programs, providers and limited budgetary resources.

The Long Term Care Rebalancing Advisory Committee recommended the following:

- *Continue the Rebalancing Advisory Committee:*
  As the state continues to consider options for improving long-term care delivery the Committees should be continued as an advisory body for the Medicaid Agency as prescribed in SJR 84. The Committee would work with the Medicaid Commissioner to gather stakeholder input on rebalancing projects and advise Medicaid on the design and implementation of any rebalancing projects. The Committee would also work with the Commissioner to determine the scope of any additional research pursued consistent with the recommendations in this report. The continued input of Senator Coleman and the Department of Senior Services on the Committee would be required to ensure maximum effectiveness.

  Status: Ongoing. Meetings are scheduled as needed. Quarterly updates are provided to Committee.

- *Implement a PACE project in a specific geographic area of the state:*
  More than 30 states have implemented Programs of All-inclusive Care for the Elderly (PACE) to provide community based services to persons eligible for nursing facility services. This Medicare based program focuses on personalized care delivered through adult day health centers. Although the Committee recommended that the Medicaid Agency work with interested providers to implement PACE in at least one geographic area in the state, at least three provider organizations in Alabama have expressed interest or are actively developing PACE programs in the State.

  Status: The first PACE site will open in Mobile in January 2012. There are number of organizations pursuing the development of a PACE program in Alabama.

- *Implement an Alabama Community Transition (ACT) waiver:*
  This waiver would specifically target individuals who desire to return to the community. The ACT waiver would be based upon the Money Follows the Person model, promoting consumer-directed options intended to give individuals the opportunity to have greater control and choice in identifying, accessing and managing their long-term care services and supports. The ACT waiver would include services specifically designed for transitioning individuals—enhanced case management, transitional assistance services, home modification, and others.

  Status: The ACT Waiver was approved with an effective date of April 1, 2011. The first enrollments should begin in January 2012.

- *Build on existing capacity to pilot promising elements of other state programs:*
  There are many options for improving the quality, effectiveness and consumer-direction of long-term care delivery while pursuing rebalancing. The Committee recommends that the Medicaid Agency and ADSS use existing flexibility to pilot ideas described in this report and others that may be identified going forward. Specifically, these entities should investigate opportunities for collaboration that could incorporate enhanced long-term care case management (similar to the Georgia SOURCE program) with the consumer empowerment efforts already underway in the Aging and Disability Resource Centers. Disease management, care transitions, chronic disease self-management, consumer

directed long-term care services and other promising models should be investigated and piloted where appropriate and budget neutral.

Status: Ongoing. Examples are the addition of transitional case management as a component of all HCBS Waivers and in the Optional Targeted Case Management benefit. Slots are being reserved in all HCBS Waivers for individuals transitioning out of the institution.

- *Complete a professional, comprehensive study of the current long-term care environment in Alabama and the most promising models for rebalancing given the needs of Alabamans and the existing long-term care infrastructure.*
  This recommendation is consistent with the recommendation of the Economic Impact Subcommittee. The exact components of this study could be determined in consultation with Advisory Committee members, Medicaid and the Department of Senior Services.

  Status: The State is still seeking funding for this recommendation.

Current Long Term Care System

States have wide latitude in designing Medicaid long-term care systems. Only nursing facility and home health services are mandatory, and states have discretion in setting eligibility criteria and can establish limits on the amount, duration, and scope of all covered services. In Alabama, several choices are currently offered to individuals applying for long term care services. Information is published in the Medicaid Recipient Handbook and available on Medicaid's website about the availability of both nursing home, home health, and home and community-based services.

Average number of Medicaid nursing home beds in FY 2010:	26,737
Number of approved HCBS Waiver slots as of October 2010:	16,084
Daily average Medicaid recipients in nursing homes:	16,000

- The Elderly and Disabled Waiver provides services to individuals who might otherwise be placed in nursing homes. The services provided by this waiver are: case management, homemaker, personal care, adult day health, skilled respite care, unskilled respite, companion service and home delivered meals. It is operated jointly by the Alabama Department of Senior Services and the Alabama Department of Public Health. This waiver is approved to serve 9,205 individuals.

- The HCBS Waiver for Individuals with Intellectual Disabilities serves individuals who meet the definition of mental retardation. This waiver provides services to individuals who might otherwise be placed in intermediate care facilities for the mentally retarded (ICF/MR). The services provided by this waiver are: residential habilitation, day habilitation, prevocational services, supported employment, occupational therapy, speech and language therapy, physical therapy, behavior therapy, adult companion service, respite care-home and group home, personal care (worksite, transportation), environmental modifications, specialized medical equipment, medical supplies, skilled nursing, crisis intervention, community specialist, individual job coach and developer, and assistive technology. It is operated by the Alabama Department of Mental Health and is approved to serve 5,260 participants.

- The SAIL Waiver serves adults with specific medical diagnoses who are at risk of being institutionalized in nursing homes. These diagnoses include: quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke, and other substantial neurological impairments, severely debilitating diseases or rare genetic disease. The services provided by this waiver are: case management, personal care, personal assistance, environmental accessibility adaptations, personal emergency response systems, medical supplies, minor assistive technology and assistive technology. It is operated by the Alabama Department of Rehabilitation Services. The SAIL Waiver is approved to serve 660 participants.

- The Technology Assisted Waiver for Adults provides private duty nursing, personal care/attendant services, assistive technology, and medical supplies to individuals with disabilities who would otherwise require more costly nursing facility care. This waiver serves adults with complex medical conditions who are ventilator-dependent or who have tracheostomies. It is operated by the Alabama Medicaid Agency. This waiver serves 40 participants.

- The HIV/AIDS Waiver provides case management, homemaker services, personal care, respite care, skilled nursing, and companion services to individuals with a diagnosis of HIV/AIDS and related illness who would otherwise require more costly nursing facility care. It is operated by the Alabama Department of Public Health. The waiver will serve 150 individuals each year.

- Alabama's Living at Home Waiver provides a wide array of services for individuals with a diagnosis of Mental Retardation who would otherwise require more costly services in an Intermediate Care facility/Mentally Retarded. It is operated by the Department of Mental Health. The Living at Home Waiver is approved to serve 569 participants.

- The Alabama Community Transition Waiver (ACT) is the result of a recommendation from the Long Term Care Rebalancing Advisory Committee. The ACT Waiver will provide services to individuals with disabilities or long term illnesses who currently live in a nursing facility and who desire to transition to the home or community setting. The ACT Waiver will also offer a consumer-directed option which will give individuals the opportunity to have greater involvement, control, and choice in identifying, accessing, and managing long term services and community supports. It is operated by the Department of Rehabilitation Services. The ACT Waiver is approved to serve 200 participants.

- The Alabama Medicaid Agency Home Health program provides services to help individuals with illnesses, injuries, or disabilities to receive quality care at home. Through the utilization of registered nurses, licensed practical nurses, home health aides/orderlies, physical therapists, occupational therapists, speech therapists, respiratory therapists, and medical equipment and supplies, recipients are provided services that are needed for them to remain at home and maintain their highest level of independence.

- The Alabama Long Term Care Ombudsman Program enables each Area Agency on Aging to hire, at a minimum, a full-time Ombudsman to provide education and advocacy supports to individuals in long term care facilities. The Older American's Act requires an Ombudsman program that is responsive to the needs of persons in long term care facilities.

Current State Agency Activities

In addition to Medicaid's activities, there are a variety of programs provided by other state agencies that gives the elderly and disabled population a choice of where to receive long-term care services and supports. The following section illustrates the activities of each Agency:

Department of Human Resources

The Department of Human Resources (DHR) has various initiatives targeting individuals through Adult Protective Services (APS). The main population served by APS are individuals that are 18 years of age or older whose behavior indicates that they are mentally incapable of adequately caring for themselves without serious consequences to themselves or others. Additional characteristics include a physical or mental impairment that renders them unable to protect themselves from abuse, neglect or exploitation, sexual abuse, or emotional abuse.

The typical APS client has no guardian, relative, or other appropriate person willing and able to assume the kind and degree of protective supervision required under the circumstances.

The Alabama APS statute requires "the least possible restriction on personal liberty" and provides that the court "give preference in making a determination to the least drastic alternative." APS policies are written in accordance with this statute.

Community Based Services Provided by DHR:

- Targeted Case Management is available statewide
- Case Management for Protective Services only is available statewide (Includes APS service provided to Medicaid Waiver recipients)
- DHR Adult Foster Care-available statewide
- Emergency Shelter is available statewide
- Adult Day Care is available in 20 counties
- Mental Health Diagnosis and Evaluation/Counseling is available statewide
- Group Homes with minimal utilization at this time
- Homemaker Services are available as needed on an emergency basis
- Referral to other community services is available statewide

DHR has a protocol that uses information from various sources in identifying individuals that need community based services. Rarely do APS recipients self report their needs. The majority of the time reports for assistance come from family, neighbors, health care providers, financial institutions, and others.

Once a report is received an assessment is completed. An assessment includes: identifying information, socialization and recreational information, training needs for community living, vocational needs, physical needs, medical care, nutritional concerns, social and emotional status, housing/physical environment needs, resource analysis, and transportation or other service needs. The individual with needs and their advocate are included in the development of individual case plans. Case managers maintain face to face contact with each client at least on a quarterly basis and more frequently when required by the case plan. The case managers report to a supervisor regularly. Management reports are generated for each case manager, the county APS program,

and aggregate statewide program. County Director's annual evaluations include the effectiveness of the APS program in their county.

Waiting List:
With the variety of services available through DHR, there is not a traditional waiting list. There is no waiting list for foster care. There is also no waiting list for individuals to transition from an institution to the community. Periodically, there is a short waiting list for adult day care. When a waiting list exists, prioritization is based on individuals with the highest risk. In emergency situations, day care can be provided in an alternative arrangement until traditional day care service is available.

Evaluation of Community Needs and Supports:
On an annual basis DHR staff meets with stakeholders to evaluate the current programs and address any unmet needs. The typical stakeholder group includes: members of the community, law enforcement, Probate and Circuit Court judges, physicians, mental health staff, public health staff, attorneys, assisted living providers, churches, hospitals, day care providers, and the Veterans Administration. The general public also has a comment opportunity when DHR promulgates administrative rules for program operation. Input is encouraged from a wide range of disciplines.

Goals for the Future:
Future goals for DHR and APS include goals to increase the protection of adults at risk of abuse, neglect, or exploitation by achieving the nationally recommended average caseload of 25. Secondly, DHR commits to initiate all investigations of alleged abuse, neglect, and exploitation within seven days of contact. To accomplish these goals, DHR intends to increase the number of County staff by 13 social workers and two supervisors; identify and allocate staff to County Departments based on recommended caseload standards, and a projected increase of the targeted population; provide training to County DHR staff on policies and procedures for investigations; monitor first victim contact reports; require corrective action plans when a County's compliance rate for initiation of investigations falls below 95%; and collaborate with national organizations and communicate to Congress the need to fund the Elder Justice Act. DHR continues to participate in discussions of the Long Term Care Rebalancing Committee's recommendations.

Funding:
Funding sources for DHR and the APS program are the Social Services Block Grant, Title XIX funds, and State funds.

Alabama Department of Rehabilitation Services

The Alabama Department of Rehabilitation Services (ADRS) serves individuals through the State of Alabama Independent Living (SAIL) Waiver who have neurological disabilities, meet the nursing facility level of care criteria and are between the ages of 18-60 years of age.

Community Based Services Provided by ADRS:

- Case Management
- Personal Care
- Personal Assistant Services to disabled individuals who are employed
- Medical services,
- Personal Emergency Response System
- Assistive Technology
- Environmental Accessibility Adaptation

Evaluation of Community Needs and Supports:
ADRS screens all interested persons for eligibility into one of its four programs available within the SAIL Division. All those eligible for services are assessed according to program eligibility criteria. For those whose name is placed on the referral list, a referral is made to the Independent Living Specialist to ensure community services are maximized to ensure some services are delivered and institutional placement is diverted during the time on the referral list.
Upon admission to the waiver program, the client's needs are assessed monthly to ensure that all needs are met and services are provided according to the waiver document. Clients are additionally referred to community resources to assist the client to receive needed non-waiver services. Monthly visits by the case manager ensure that the client's health and safety needs are met through the provision of services and that the client's plan of care remains appropriate.

For clients entering the hospital or nursing facility, the case manager conducts a visit upon discharge to ensure the plan of care remains appropriate to meet the needs of the client and to ensure the client's health needs are met. For clients who enter a nursing facility within his/her eligibility period, automatic reinstatement is available back onto the waiver program. This option is available for those whose institutional stay is less than 100 days. The local staff and the SAIL state office maintain a professional working relationship to ensure the client needs are met and eligibility determined as quickly as possible.

Transitional services have been available on the SAIL waiver since 2007 allowing for transition from the nursing home for those there more than 90 days and whose transition is expected to occur within 180 days.

SAIL partnered with the Alabama Department of Senior Services to implement the Personal Choices program allowing for a self-directed option within personal care services.

Referral List:
Referrals to the waivers are accepted from the individual themselves or from anyone who has knowledge of the individual's need for assistance. The referred individual is added to the referral list if they want waiver services and will potentially be eligible for the program once a slot is available. Referrals can be made to any of the seven area SAIL offices as well as the SAIL State office. ADRS/SAIL uses a referral screening tool for each of its waivers or other SAIL program.

A referral list is maintained for individuals that have expressed an interest in applying to either waiver or other programs. There are approximately 400 individuals on the referral list statewide.

ADRS/SAIL also provides the screening and targeted case management for the Technology Assisted Waiver for Adults. This waiver was amended in February 2011 that broadened the eligibility criteria allowing for additional persons to be considered. ADRS/SAIL is responsible for the screening for the TA Waiver and follows the above mentioned criteria to screen. This waiver has 40 slots available statewide. The case managers visit monthly to ensure appropriateness of service and the plan of care to ensure the health and safety of the individual in the community. Currently, there is no waiting list for the TA Waiver program.

Goals for the Future:
Future plans include the implementation of the Alabama Community Transition Waiver for persons currently residing in nursing facilities or long term care units. This waiver makes 200 slots available statewide. ADRS/SAIL will be considered the operating agency for this waiver program. Implementation should occur by the end of the calendar year. Also, SAIL expects to expand the Personal Choices statewide before the end of calendar year 2012 allowing for those persons on the waiver program a self-directed option for the delivery of personal care. Currently, it is only available in 7 counties in West Alabama. SAIL continues to partner with CMS, Alabama Medicaid and other agencies to maximize services to individuals eligible for waiver services in the state. SAIL will continue to participate on the LTC Rebalancing Committee.

Funding:
ADRS uses a combination of state and federal funding to provide SAIL waiver.

Alabama Department of Public Health

The Alabama Department of Public Health (ADPH) has community based programs with a target population of the elderly and disabled through the Elderly and Disabled Waiver. ADPH also operates the HIV/AIDS Waiver and provides community services to individuals diagnosed with HIV/AIDS or related illnesses. To qualify for either waiver, an individual has to meet the nursing facility level of care and meet the financial eligibility criteria for the program.

Community Based Programs Provided by ADPH:

- Elderly and Disabled are available statewide
- HIV/AIDS Waiver are available statewide

Evaluation of Community Needs and Supports:
ADPH identifies community needs and supports of the target population through initial assessments. Once enrolled in either waiver program, the assessment of the client is ongoing. Individuals that are referred to the waivers are also given information to help link them to non-waiver services and supports, Medicaid State Plan services, and other home and community based service options to meet their identified needs. Community resource directories are readily available for case management staff to make appropriate referrals. The referrals to non-waiver services will assist in meeting an individual's needs until their waiver application is approved for admission.

Upon admission to a waiver program the case manager conducts a face-to-face assessment in the client's home. A plan of care is developed based on the individual's strengths, needs, goals, and choices. The caregiver(s) and others involved in providing care to the client are involved in the care planning process. The plan is individualized and includes waiver and non-waiver services which are provided to maintain the individual in the community setting. The case manager conducts monthly face-to-face visits to monitor the care plan and modify it as needed based on outcomes and client satisfaction.

In an effort to maintain the client in the community, the case manager monitors the waiver clients to ensure they are healthy and safe in the community. In the event that a client is hospitalized or admitted to a nursing facility, the needs of the clients will be reevaluated upon return to the community. Case managers will recommend different services or additional service hours to address clients' changing needs. Case Management Supervisors audit client case records every two months to monitor compliance with program policies and procedures. Audit results are reported to the Public Health Area Social Work Director and the operating agency state office. Additionally, the Medicaid Agency conducts yearly quality assurance audits of the Public Health area and the operating agency state office. There are several individuals responsible for monitoring care plan compliance. Medicaid's Quality Assurance Division, along with the Director of ADPH Division of Community Services, ADPH QA Consultant, area Social Work Directors, and area Case Management Supervisors, are all involved in the quality assurance process.

Referral List:
Referrals to the waivers are accepted from the individual themselves or from anyone who has knowledge of the individual's need for assistance. The referred individual is added to the referral list if they want waiver services and will potentially be eligible for the program once a slot is available. Referrals can be made to the state or county health department. ADPH uses a referral screening tool for each of its waivers. This tool helps assess potential waiver eligibility and

needs. A more in-depth assessment tool and procedure were developed to assess waiver eligibility and needs once a waiver slot is assigned and the application process begins. Additional tools have been developed to assess the individual's functional and nutritional needs.

A referral list is maintained for individuals that have expressed an interest in applying to either waiver. The referral list for the Elderly and Disabled waiver is maintained by county. There are currently 4,800 individuals on the referral list statewide.

An individual is added to the referral list if they are likely to be eligible. Once a slot is available, financial and medical eligibility will be reviewed. The average amount of time on the referral list varies statewide based on the county slot allocation and the length of the referral list.

The HIV/AIDS Waiver has slots available for immediate assignment. The HIV/AIDS Waiver includes Transitional Case Management. This allows the case manager to complete an assessment on an individual in a nursing facility if needed. Transitional Case Management can be provided in a nursing facility up to 180 days prior to discharge to the community.

ADPH policies allow for flexibility in managing a client's needs and their desire to remain in the community. Transitional case management is available for individuals already in an institution who wish to transition to the community. While waiver eligibility has to be terminated when a client enters a nursing facility, arrangements have been made for the client to retain their slot on the waiver through the end of the fiscal year to allow the client the opportunity to return to the community. Additionally, if a client is in an institution for less than 100 days they can be reinstated to their waiver slot after a review of the care plan and any subsequent changes.

ADPH has worked with the Medicaid Agency to open communication between case managers and Medicaid District Office staff to expedite the financial applications. The District Office worker can inform the case manager of what documents an applicant is lacking to assist the applicant as needed. The outcome of this communication is improved efficiency with which waiver applications are processed. It also allows for better communication between Medicaid and the case managers regarding terminations of waiver eligibility, follow-up on loss of financial eligibility, and the financial aspects related to nursing home admissions and discharges.

For the Elderly and Disabled Waiver, there are several groups that provide input to ADPH about its programs and the community needs. ADPH actively discusses program offerings with other state agencies including the Alabama Department of Senior Services and the Medicaid Agency. Collaboration with other state agencies allows for a diverse population to be served and increases the availability of community services.

For the HIV/AIDS Waiver, ADPH works with the HIV/AIDS Division at the health department, as well as the Medicaid Agency. ADPH reaches out to other HIV/AIDS service providers about waiver services. These interactions enable ADPH to learn more about non-waiver services available to people living with HIV/AIDS. Outreach includes such activities as case staffing, participating in advocate meetings, distributing printed materials and brochures, conducting small group training sessions, and providing conference exhibitions. ADPH also uses a Medicaid representative, a local community based organization and both an AIDS educator and a peer mentor from the ADPH HIV/AIDS division to participate in orientation and training for HIV/AIDS Waiver Case Managers.

Goals for the Future:
Future plans for ADPH's activities to maintain individuals in the community include several commitments. ADPH plans to offer Transitional Case Management through the Elderly and Disabled Waiver for individuals that are currently residing in an institution, but wish to return to the community. ADPH will also promote the Transitional Case Management service available in the HIV/AIDS Waiver. This service is underutilized in the HIV/AIDS Waiver. ADPH plans to provide education and outreach to promote this service in the waiver. ADPH continues to participate in discussions of the Long Term Care Rebalancing Committee's recommendations.

Funding: ADPH uses a combination of state and federal funding to provide the Elderly and Disabled Waiver and the HIV/AIDS Waiver.

Alabama Department of Senior Services

The Alabama Department of Senior Services (ADSS) primarily serves the elderly and disabled population. Individuals who meet the nursing facility level of care can apply for the Elderly and Disabled Waiver. Through Title III of the Older Americans Act of 1965, ADSS is authorized to serve individuals age 60 and older through community supports in order to help these individuals remain independent and live in their own homes. A majority of that population would likely require institutionalization without the coordinated system of care provided through the aging network. ADSS has also been the recipient of several grants that provide transitional services and preventative services to help individuals with dementia, chronic disease, and disabilities to live in the least restrictive setting.

Community Based Programs Provided by ADSS:

- Elderly and Disabled Waiver is available statewide
- Personal Choices, self direction offered through the waiver is available in 10 counties
- Title III AOA services is available statewide
- Aging and Disability Resource Center (ADRC) pilot is available in certain counties
- Senior RX is available statewide
- Long Term Care Ombudsman Program is available statewide

ADSS has been involved in various initiatives to determine the needs of the community and specifically the elderly and disabled population. ADSS was part of the original Olmstead Core Planning Workgroup in 2002. Additionally, ADSS participates in numerous committees which include: individuals with disabilities, their advocates, community members, and family of the target population.

Evaluation of Community Needs and Supports:
ADSS has created several tools to evaluate an individual's needs to live safely in the community. These tools include: HCBS Assessment tool, DON-R PASS tool, AIMS database, Personal Choices Handbook/Personal Support Plan, Alabama Connect, and the Title III Enrollment form with Nutrition Risk and ADL assessment. The combination of these tools will allow ADSS to determine what services are most appropriate for an individual and how to get the process started.

ADSS currently uses various resources to identify community needs and supports of the target population. Focus groups have been used in the Olmstead planning process. There is a yearly public hearing for state planning to afford citizens the opportunity to provide input regarding their priorities for future state programs.

An individual that's interested in applying for the Elderly and Disabled Waiver can inquire at their local Area Agency on Aging (AAA). In addition to the AAA's an individual can inquire through a toll-free telephone number or access information through the ADSS website. An intake person will gather their contact information and the appropriate staff person will help them get the process started.

The admission process to the Elderly and Disabled Waiver begins when the applicant is added to the referral list. The waiver program currently maintains a referral list for individuals interested in receiving services. At the time the individual is added to the referral, it has not been determined if the applicant meets the eligibility requirements of the program. Once a slot becomes available, the client will be assessed for medical and financial eligibility for participation in the program. The referral list is "worked" based on the date the referral is

received. The length of time from referral to the start of services varies depending on the time it takes for financial eligibility to be completed and the required medical eligibility screening to occur.

Every three years, ADSS conducts a needs assessment for consumers and caregivers. There is a Lifespan Respite Grant being used for collaboration with University of Alabama-Birmingham to conduct a needs assessment with providers to determine what education and supports are needed for caregivers.

The State Health Insurance Program (SHIP) assists at risk beneficiaries in rural areas with one-on-one counseling and assistance regarding their health insurance. In reaching that population, SHIP can assist those with limited incomes who may qualify for extra benefits.

ADSS also contracts with the Department of Human Resources to target nutritionally at risk individuals who are eligible for food assistance.

Goals for the Future:
ADSS's future plans include various initiatives to serve their target population more efficiently. The AIMS database will be expanded to increase the ability to track and monitor clients who apply for services. ADSS plans to prioritize those individuals who are at highest risk for institutionalization. An intake assessment will include: nutrition risk assessment, ADL assessment, and the individual's percent of the poverty level. A combination of scores related to the aforementioned assessments will identify the individuals with the highest needs.

ADSS has partnered with Medicaid to use funding through the System Transformation Grant to develop an electronic tool for the Elderly and Disabled Waiver program—the Online Document Management (ODM) tool. This tool establishes interoperability between state agencies regarding the clients that are served. ADSS actively participates in stakeholder groups related to the development of system changes for the establishment of a State Health Information Exchange.

There are plans to implement statewide ADRC's by FY14. ADSS has completed an assessment to participate in the Veterans consumer Directed Home and Community Based voucher program. This program will allow the AAA's to contract with the VA medical centers to provide Home and Community based services for Veterans.

Funding:
Funding for ADSS activities is a combination of federal and state funds.

The Alabama Department of Mental Health

Because the Department of Mental Health has faced a number of challenges with providing services and supports to the population they are charged to serve, the format of their information is different than those of the other agencies discussed in this summary report.

The Alabama Department of Mental Health is charged in Alabama Code Section 22-50-1, *et seq.,* to provide services for persons with mental illness (MI), intellectual disabilities (ID), and substance abuse (SA) problems. The Department provides these services through two separate service areas – The Division of Mental Illness and Substance Abuse Services and the Division of Developmental Disabilities. Each division is represented by an Associate Commissioner/Director who reports to the Commissioner. Broadly speaking, ADMH fulfills this charge through: (1) the operation of six state in-patient facilities/hospitals (has closed in the past, four other developmental centers, one hospital, three nursing homes and two institutional adolescent units), and (2) contractual relationships with community programs throughout the state. Many of these community programs are authorized under Alabama Code Section 22-51-1, *et seq.* (commonly referred to as 310 Boards).

The Division of Mental Illness and Substance Abuse Services contracts with providers of community based services, both public and private, to provide a broad array of services ranging from case management to intensive residential services. Most mental illness community services are provided through contracts with local mental health centers.

The Division of Intellectual Disabilities contracts with providers of community based services, both public and private. These providers include ARCs, VOA (Volunteers of America), local ID 310 Boards, comprehensive (MI, SA & ID service) 310 Boards, as well as others.

<u>Community Based Programs Provided by ADMH:</u>

- Community Mental Health Centers
- Alabama Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID Waiver) is available statewide.
- Alabama HCBS Living at Home Waiver for Persons with Intellectual Disabilities (LAH Waiver) is available statewide.
- Comprehensive Support Services
- Community Substance Abuse Services

Approximately 100,000 individuals with mental illness receive community mental health services per year. There are 25 Community Mental Health Centers that contract with ADMH to provide direct care services to individuals with mental illness in the community. Services provided in the community include, but are not limited to, community based residential treatment, medication management, day treatment, counseling, family education & support, in-home intervention, assertive community treatment (ACT), emergency services, in-patient services, out-patient services, case management, and supported employment services. In times of natural or man-made disasters, ADMH also provides disaster response services including crisis counseling to local affected communities.

Approximately 5,800 individuals with intellectual disabilities receive community services through the Living at Home Waiver and the ID Waiver per year. There are over 200 local providers that contract with ADMH to provide ID community services. Three Comprehensive Support Services teams are available to assess the need for, and assist with, providing an array of

supports to individuals who require specialized services. Additionally, these teams will assist providers with developing internal capacity related to these and other specialty areas. The three Comprehensive Support Services teams are located in Decatur, Wetumpka, and Mobile. ADMH Regional Offices are located in Birmingham, Decatur, Mobile, and Wetumpka. Services provided to individuals with intellectual disabilities include intensive care, residential care, day training/activities, case management, crisis intervention/stabilization, occupational therapy/ physical therapy, in-home care/interventions, and assistance in affordable housing.

Approximately 26,000 individuals with substance use disorders receive community substance abuse services per year. There are 60 substance abuse providers across the state that contract with ADMH to provide services in the community. There are a total of 102 certified substance abuse providers in the state, with only 60 receiving state funds to provide services. Services provided in the community include, but are not limited to, residential treatment, intensive outpatient treatment, medication assisted treatment, crisis services, detoxification services, and prevention services.

Needs Assessment of Population:
In 2007, regional planning groups made up of consumers, family members, mental health providers, and other stakeholders developed plans for new services and protocols designed to transfer the acute care function from state hospitals admission units to local community settings. These efforts resulted in a number of residential programs obtaining "designated mental health facility" status (community-based psychiatric units or hospitals that may serve committed patients outside of a state-run institution), the purchase of local inpatient care, increased psychiatric time, development of a Psychiatric Assessment Center in an area of high state hospital admissions, and the establishment of mental health service teams, consistent with "best practices," such as Assertive Community Treatment teams, Adult In-Home Intervention teams, and Bridge teams.

In FY09, extended care residents at Bryce and Searcy were evaluated to identify needed community services to permit discharge from the hospitals. In addition, residents living in community residential programs for over a year were evaluated to determine services needed to promote independent living in community. The planning process continued into FY10 and was incorporated into planning for the sale of Bryce Hospital to the University of Alabama and subsequent construction of a smaller, state of the art hospital. Final plans were developed and approved by the Bryce Consumer Transitioning Work Group, the Mental Illness Coordinating Subcommittee (both incorporating a wide range of stakeholder representation), and approved by the Commissioner.

The community provider network in Alabama's MI Regions 2 and 4 established boards for the purposes of promoting service coordination and monitoring of project goals at a regional level. New services began in June 2010 in Region 2 (North Central Alabama in the Bryce Hospital-served area) and in August 2010 in Region 4 (South Alabama in the Searcy Hospital-served area). The plans included the development of a variety of community services such as an increase in permanent supportive housing units, augmenting current residential homes, establishing a Medication, Observation, and Meals (MOM) apartment model, increase in small capacity—three-bed homes, the utilization of Peer Bridger Teams, an increase of Peer Support Services, and the use of flex funds.

Assessment Tools:
ADMH/Division of Developmental Disabilities Level of Care requires documentation of a full scale IQ below 70; a diagnosis of Intellectual Disability with an age of onset prior to age 18, and significant functional limitations in three of six areas of life activities (Self Care; Receptive and

Expressive Language; Learning; Mobility; Self Direction; Capacity for Independent Living). The full scale IQ is obtained from a psychological evaluation, and the age of onset is obtained, if not from the evaluation, from ancillary documentation such as a previous psychological or school record. The limitations in adaptive functioning are determined from the ICAP (Inventory for Client and Agency Planning, Riverside Press). If necessary to support a conclusive determination, an ABS will be required, but only when maladaptive behavior appears to be the only factor causing the ICAP to qualify an otherwise borderline individual.

The admission process to both the ID and LAH Waiver begins with contacting the Department's Call Center at 1-800-361-4491. The Call Center will gather basic information and make a referral to the appropriate designated 310 agencies. The 310 agencies coordinate applications for waiting list and enrollment in the DD Waivers. Applicants are determined eligible for the Waiver and placed on a waiting list, ranked by criticality and length of time waiting. Applicants are selected from the waiting list in rank order. Selection criteria are defined in the Administrative Code.

Evaluation:
ADMH/Division of Developmental Disabilities Level of Care requires documentation of a full scale IQ below 70; a diagnosis of Intellectual Disability with an age of onset prior to age 18, and significant functional limitations in three of six areas of life activities (Self Care; Receptive and Expressive Language; Learning; Mobility; Self Direction; Capacity for Independent Living). The full scale IQ is obtained from a psychological evaluation, and the age of onset is obtained, if not from the evaluation, from ancillary documentation such as a previous psychological or school record. The limitations in adaptive functioning are determined from the ICAP (Inventory for Client and Agency Planning, Riverside Press). If necessary to support a conclusive determination, an ABS will be required, but only when maladaptive behavior appears to be the only factor causing the ICAP to qualify an otherwise borderline individual.

Utilizing a discovery process, this refers to a set of strategies that explore the lives of persons with disabilities as a means of gaining necessary information and perspective as opposed to traditional approaches that require individuals to perform and compare their performance against others or standards as an indication of one's skills and needs. It's an information gathering process, a guide that suggests questions to ask in order to discover information about an applicant. In addition, the time spent with the applicant and the relationship that is formed provides a facilitator the knowledge and insight into the life experiences and contributions of the applicant. These life experiences and contributions provide direction for employment.

This approach differs from traditional assessments in that it doesn't measure anything, and it supports utilizing involvement and interaction with the applicant in natural settings rather than in test settings. More importantly, it provides a complete picture of an applicant, rather than looking at one or two skill areas. A specific job can then be identified consistent with the person's entire life, not merely from an instance of performance. The strategy recognizes the importance of focusing on the applicant's demonstrated skills, experiences, home, family, friends, neighborhood, informal supports, preferences, connections and need for accommodation.

Process for Obtaining a Second Opinion

If the applicant is determined eligible**,** his/her name will be added to the waiting list. The applicant will receive a memorandum (an Initial Notification of Preliminary Determination of Eligibility) from the division stating they have been added to the waiting list indicating the service groups for which the applicant is shown to be waiting. This notification will also explain how the waiting list works.

A second page describes how to request a review if the applicant disagrees with being entered on the waiting list or with the specified service groups. The instructions for requesting a review are very specific as to whom the applicant should contact, that the request must be in writing, and that the request needs to be received within 15 days after the date the notification was sent to the applicant. The review process — first review is with the regional community services office, and then, if there is still disagreement, the second review is with the Associate Commissioner of the Division of Intellectual Disabilities. Also described are the types of reviews that may occur (in-person interview, teleconference, or just a review of documents) and who can participate with the applicant in the review.

A third page describes the eligibility requirements for the Medicaid Home and Community Based Waiver Programs for individuals with intellectual disabilities.

If the applicant is determined ineligible**,** the applicant will receive a memorandum regarding denial of eligibility. This notification will state that the application has been denied specifying the reason why (it will describe the statutory and/or regulatory requirement that has not been met).

The appeal process — begins with a written request from the applicant, either to the Division of Intellectual Disabilities or to the Alabama Medicaid Agency, with specific timelines involved for each. If the applicant appeals first to the Division of Intellectual Disabilities, he or she will be entitled to a review by the Associate Commissioner, who will produce a written determination. If the individual is dissatisfied with that determination, he/she has the right to appeal to the Alabama Medicaid Agency. The notification fully explains the process of appeal to both agencies. ***Note:*** *the applicant is not required to appeal first to the Division of Developmental Disabilities but may appeal initially to the Medicaid Agency.*

Changes in Infrastructure to Prevent or Correct Improper Institutionalization:

During the implementation of the year 2000 *Wyatt* settlement agreement that settled what was originally *Wyatt v. Stickney,* at the time the longest running lawsuit on rights and services due people committed and served in institutions, and since, ADMH has further planned and executed numerous major initiatives that effectuate the letter and spirit of *Olmstead.* For example, among other things, the *Wyatt* settlement required that a minimum of three hundred beds in extended-care psychiatric hospitals and 300 people residing in developmental centers (intermediate care facilities for people with intellectual disability, i.e. ICF/ID) be closed and the individuals placed in community-based settings, respectively. ADMH deliberately declined to agree to close any specific facility that it operated. However, as it moved people with mental illness and intellectual disability to community-based settings, it decided, on its own, to close in a comprehensive consolidation plan, three developmental centers, two nursing homes (and the third and last one was closed thereafter in 2009), co-located one psychiatric hospital with another; eventually closing the relocated hospital and established community services support teams for ID residents. (*See e.g.,* Attachments 2 and 3*).* In March 2011, DMH announced the closure of its last and oldest developmental center, the W.D. Partlow facility in Tuscaloosa. Partlow has been downsized since, is down to less than 10 residents at this writing, and will be closed by the end of December 2011.

Likewise in 2000, to foster more housing opportunities for people with serious mental illnesses or intellectual disabilities, ADMH embarked upon a two year partnership with the Alabama Housing Finance Authority to prioritize portions of housing developments financed through a combination of low-income housing tax credits and the Home Investment Partnership Program. (*See, e.g.*, Attachments 4 and 5.) These plans were approved by HUD and netted up to 15 percent of housing units developed through funding from these two programs for the years 2000 and 2001. Under this initiative, people with mental disabilities have a priority for occupancy up to the total of reserved units and when they vacate the premises that priority remains. Only if after working with local mental health service providers and ADMH, housing managers cannot find a person with mental disabilities to occupy the premises, may other tenants occupy that small, integrated percentage of these units. ADMH also created a housing consultant/advocate position to assist consumers with issues that may arise with the managers of these units (and others) with problems they may have with landlords related to the tenants' illness or condition. In 2011, a federal act, the *Frank Melville Supportive Housing Investment Act of 2010*, was passed that authorizes similar housing practices as a matter of law.

Parallel to the implementation of the *Wyatt* settlement agreement, ADMH also settled a law suit filed by deaf or hard of hearing consumers in a class action suit, alleging violations of the Americans with Disabilities Act, among other claims. (*See,* Settlement Agreement, *Bailey v. Alabama Department of Mental Health and Mental Retardation*).

For people with intellectual disability (ID), and again before the *Wyatt* settlement agreement could be implemented, another lawsuit was filed on behalf of individuals with intellectual disability who were already living in community-based setting, but who sought Medicaid home and community-based services waivers. Once *Wyatt* was settled, the Department attempted and, ultimately after some limited litigation, settled this "ID waiting list case" by incorporating more well-defined and noticed due process procedures relating to denials and/or delays in granting eligibility and/or services to people with ID. *See e.g., Susan J. v. Riley,* 254 F.R.D. 439 (class certification approval-Attachment 7.a.); *Susan J. v. Riley,* 616 F.Supp.2d 1219 (M.D. Ala. 2009) (order granting defendants partial summary judgment – Attachment 7.b.); and Settlement Agreement, *Susan J. v. Riley (*Attachment 7.c.). Read together, these documents support the proposition that Alabama may cap its home and community-based services waiver programs and operate a waiting list serving applicants in priority based upon their levels of severity and emergent needs, as it has designed.

<u>Groups Involved in the Development of Services in Integrated Settings:</u>
As a result of the *Wyatt* "right to treatment" litigation and in response to the *Olmstead* "integration mandate," the Alabama Department of Mental Health has been an active participant in Alabama's systematic and inclusionary plan to reduce levels of institutional care and expand access to community-based services.

Upon the inception of the Home and Community Based Services Expansion Project, ADMH was a member of the Olmstead Planning Core Workgroup established by the lead agency, Alabama Medicaid. The workgroup comprised of state agencies, consumer and advocacy groups, and other stakeholder representatives was charged with designing a three year strategic plan for expanding home and community-based services. Through the Wyatt settlement agreement, ADMH was required to implement a statewide community education plan, reduce institutional levels, and develop more community options. Several workgroups (comprised of ADMH Administrators and hospital staff, consumer and family members, public and private mental health providers, and advocacy groups) were established to form the Wyatt Implementation Plan.

This Wyatt plan and three-year Olmstead plan converged to create the roadmap to drive a reduction in the use of state psychiatric institutions and expand community service options.

The converged plan supported the implementation of a census reduction model in which the care of individuals housed within the States' extended care wards would be transferred to the community provider network. This resulted in a significant expansion of residential services many of which reflected the development of new "specialty," and small capacity (three bed) residential models to address the unique needs of extended care residents such as medical and forensic. Expert training and consultation was also provided through Olmstead funds and other funding sources to include deaf interpreter training, person centered discharge planning, and dual diagnosis services.

Agency Successes in Moving Individuals to Integrated Settings:
Through the efforts of the MI Division, the Alabama Department of Mental Health has demonstrated less reliance upon state psychiatric inpatient services by shifting funding and focus to less costly, but more effective community services and supports. Since 1971, the census at Bryce Hospital, Alabama's oldest psychiatric hospital, dropped from over 5,000 patients to less than 400 in 2004. Strides to better serve consumers outside of inpatient settings have continued beyond those prompted by the settlement leading to a statewide reduction in hospital census; nearing a 20% reduction during the course of FY11, as well as closures of state psychiatric facilities.

To date, the latest Downsizing Project has resulted in a reduction of the extended care census at Bryce Hospital from an average daily census of 318 to 240, and a reduction in the extended care census at Searcy from a baseline average daily census of 351 to 246, exceeding the project target of 255. As of May 2011, the maximum capacity for Bryce and Searcy extended care units were formally reduced. This act further underscores the Department's commitment to operate smaller inpatient facilities and shift budgetary funds traditionally from state hospitals, to the expansion of services and supports better constructed to promote independence and inclusion into the community for consumers.

Funds continue to be dedicated for community integration and service expansion efforts through block grant dollars, general state funds, and other grant resources. Throughout the years, community integration and services expansion have been the focal point of the SAMHSA Block Grant goals and targets for mental health services. The MI Planning Council, which is the mandated body to approve the Mental Health Block Grant goals, has assured this process and their guidance has steered the enhancements to this process to expand into peer directed care that is strength-based and person-centered. In fact, over a decade ago, ADMH partnered with the MI Planning Council to apply for the Olmstead stipend which is provided to states on an annual basis. The MI Planning Council established guidelines for the submission and approval process for proposed uses of the stipend. Funding is dedicated to facilitate State's efforts to carry out the values expressed under the Olmstead decision of promoting community integration for adults with serious mental illnesses and/or co-occurring substance use disorders and children with serious emotional disturbance.

Closure of Partlow (The Last State-Run ICF/ID)
Since the implementation of the Consolidation and Closure Plan was completed in 2004, ADMH assessed the remaining individuals being served at its last intermediate care facility for people with mental retardation (now intellectual disability)(ICF/ID), the W.D. Partlow Developmental Center, and has determined that all of its residents can be better served in more community-integrated environments. Therefore, in March, 2011, the current ADMH Commissioner, Zelia

Baugh and Governor Robert Bentley decided to close Partlow, and to serve the individuals who are eligible, in home and community-based waiver services throughout Alabama. That closure is almost complete and is scheduled to end no later than December 31, 2011.

ID and MI Work Programs
ADMH's Developmental Disabilities Division (newly renamed as it seeks to attempt to expand services to broader disability populations than just those with intellectual disability) has worked with the Alabama Medicaid Agency and proposed amendments to its existing HBCS waiver programs to de-emphasize day services and emphasize more supported and integrated work services. The amendments were just approved by CMS and will be implemented beginning spring 2012. Additionally, the MI Division is also reviewing ways to shift from day programming to employment services to assisting consumers in achieving maximum quality of life, independence and self-worth.

Stakeholder and Advocate Involvement in Plan Development and Implementation:
Between January 20, 2000, when the *Wyatt* settlement agreement was signed and October, 2003, when the parties jointly moved the court to dismiss the case as all requirements had been met with substantial compliance, much involvement of stakeholders, advocates and individuals with disabilities led to implementation of DMH's initial Olmstead planning.

Prior to and during the three-year term in which the *Wyatt* Settlement Agreement contemplated the defendants' compliance, the parties and their counsel have worked diligently to ensure that the Settlement be effectuated. The Commissioner directed Department officials to prepare and diligently track an implementation plan that served as a guide to facilitate all milestones being met. *See e.g., Wyatt v. Sawyer,* Joint Status Report, January, 2001. Implementation task forces were created to address every major section of the agreement. This included not only DMH staff but also plaintiffs by and through ADAP, consumers, consumers' family members, consumer advocacy groups, DMH facility personnel and community service providers. Once the implementation plans were devised and made consistent across the relevant service divisions of DMH, the workgroups were dissolved. However, various other committees charged with implementing the plans remained active, such as the Education and Public Awareness Committee which conducted many projects to elevate the public's understanding of people with mental illness, intellectual disability and other disabilities. Further, as contemplated in the Agreement, a similar set of appointments were made, to the extent they did not already exist, as complements to most of the advisory committees to DMH and its Commissioner. This pattern was also followed in appointments to advisory bodies to the Associate Commissioners for Mental Illness (MI), Mental Retardation (MR) (now referred to as Developmental Disabilities (DD), and the MI and ID facility and community programs around the state. These advisory bodies include an advisory board of trustees appointed by the Governor, the DMH Management Steering Committee and its advisory subcommittees, the DMH and facility advocacy advisory committees, MI and ID divisional and facility continuous quality improvement committees (sometimes also referred to as quality enhancement or performance improvement committees), facility investigative review committees, and a Children's Services Advisory Committee, among others.

To implement the Settlement Agreement and to facilitate the parties carrying out their respective responsibilities pursuant to the Settlement Agreement, DMH provided required data and reports to ADAP to facilitate plaintiffs' counsel's ability to participate in treatment team meetings and review cases of class-members who moved from facility to community settings. When the plaintiffs raised issues regarding consumers' care and treatment, the parties, through counsel, have collaborated to develop workable solutions to address consumer needs. On a routine and periodic basis, ADAP met with then DMH Commissioner and other relevant DMH officials to

address compliance issues as contemplated by the Agreement. At the end of 2003, as reported in the Court's order in January 2004, this longest running civil and constitutional rights case in the United States governing appropriate treatment and care of consumers with mental illness and intellectual disability was dismissed.

In 2005, the Commissioner established the Acute Care Taskforce. This taskforce was comprised of consumers, family members, mental health providers, probate judges and law enforcement. These key stakeholders worked together to address the census overages at the state facilities and identify ways to expand acute care services in the community despite the limited funding available. The Acute Care Taskforce developed a preliminary report that not only provided a framework to address the acute care crisis, but also broadened its scope to address mental health systems transformation that is built on concepts of recovery and resiliency.

In December 2005, the Commissioner expanded the Acute Care Taskforce into four regional planning groups. The groups were divided by the catchment areas of the four state hospitals. The Commissioner appointed consumer representatives to sit on each of the regional planning groups. Along with consumer representatives, NAMI members, state facility directors, private hospital administrators, probate judges, local mental health center directors, AL Department of Mental Health advocates and law enforcement officials were a part of the regional planning groups. The planning groups were charged with developing a plan that was consistent with the concepts of SMART Governing. The plans were to first address the census overages at the state facilities, then to develop a regional plan for creating a community-based mental health system for acute care services for adults and then address long-term transformation of the mental health system in Alabama (AL Dept. of MH Acute Care Task Force Final Report).

In all four regional plans, consumer needs were placed at the center of decision making. The four plans identified areas for improvement in the continuum of care, which include consumer and family issues, substance use, legal issues and workforce and technology issues. The vision for each plan included consumers and family members as change agents, services that are outcome driven and performance-based, services tailored to geographic, cultural and linguistic diversity, and individualized treatment focused on wellness, recovery and resilience.

Each regional group identified key critical issues for each area of improvement. These issues were identified in order to move the system into a consumer driven system. These areas include, but are not limited to, the lack of variation in mental health services to meet the need of the changing SMI population, limited recovery services that are flexible and measured against individual outcomes, and day treatment options that do not ensure that recovery is the end result and that the results are achievable. Consumer and family critical issues include limited consumer directed services and the lack of peer support programs that promote recovery.

Specific goals were identified for each area of improvement. The final regional reports were submitted to the Commissioner in October 2006**.**

<u>Current Waiting List and Processes:</u>
The composition for the ID waiting list includes individuals that have a diagnosis of Intellectual Disability and meet ICF/ID Level of Care. There are 1647 people currently waiting that are not receiving services from the Division and are not on the waiting list for long term planning. The approximate time it takes for a person that is approved for a Waiver slot to be moved into the community is two months. This takes into consideration provider development, staff training, and home modifications, if necessary.

The admission process to both the ID and LAH Waiver begins with contacting the Department's Call Center at 1-800-361-4491. The Call Center will gather basic information and make a referral to the appropriate designated 310 agencies. The 310 agencies coordinate applications for waiting list and enrollment in the DD Waivers. Applicants are determined eligible for the Waiver and placed on a waiting list, ranked by criticality and length of time waiting. Applicants are selected from the waiting list in rank order. Selection criteria are defined in the Administrative Code.

Outpatient program descriptions for community mental health services has admission criteria inclusive of all ages, persons with serious mental illness / severe emotional disturbance, and persons discharged from inpatient psychiatric treatment. Each consumer admitted to treatment must be assigned to an appropriate qualified staff member or clinical treatment team who has the primary responsibility for coordination/implementation of the treatment plan.

Additional information to be completed by the designated 310 Agency:

1. Criticality summary completed within 90 days of application;
2. A psychological evaluation with the IQ range of the applicant (IQ score below 70 documented by a standardized intelligence test) including a review of all past intellectual assessments and IQ scores;
3. Documentation that the applicant has challenges with adaptive functioning (significant limitations in the applicant's effectiveness in meeting the standards of maturation, learning, personal independence, and/or social responsibility that are expected for his/her age level and cultural group, as determined by clinical assessment, and usually, standardized scales) such as the ICAP (Inventory for Client and Agency Planning);

   When there is cause to question the ICAP score, an additional clinical adaptive functioning assessment and other documentation may be requested;
4. Documentation that the applicant's level of adaptive and intellectual functioning occurred prior to the age of 18 (developmental history).

The 310 Agency will submit the completed informational packet for review to the regional community services office that serves the applicant's county and, if approved, the applicant's name will be placed on the waiting list. ADMH will make a determination of eligibility within 30 days of the receipt of the completed application. *Note: the date of application is the day a completed packet is received at the regional community services office.*

Applicants are served in priority based upon their levels of severity and emergent needs.

Goals for the Future:

ADMH's future plans include the closure of the last state operated ICF/ID due to close by 2012. At this time the Division of Development Disabilities will provide all services in the community unless a person chooses a privately operated ICF/ID.

State Monitoring and Evaluation of Completion of the Goals and Objectives of the Plan:
The Alabama Department of Mental Health monitors completion of the goals and objectives developed by consumers, family members, providers, ADMH staff, and advocates through ongoing certification reviews, community provider standards, ADMH contract requirements, monitoring by internal and external advocates, and monthly planning and evaluation meetings. Additionally, DMH, in each of its divisions, utilizes quality assurance measures to track key indicators of quality service delivery.

DMH also utilizes consumer satisfaction surveys administered directly by DMH or in the case of individuals with substance abuse disorders, by the community programs which DMH regulates and/or contracts.

Funding:
Funding for ADMH activities is a combination of federal and state funds.

Minimum Data Set Section Q Activities

Background:
The Centers for Medicare and Medicaid Services (CMS) has mandated states to develop a process for the new MDS 3.0 Section Q that requires any nursing facility resident indicating an interest in returning to the community to be given an opportunity for a face-to-face visit with a Local Contact Agency (LCA).

Section Q

- Provides a more meaningful dialogue with the resident on discharge planning goals
- Engages residents in planning
- Promotes information exchange
- Promotes discharge planning collaboration

Resident input is critical to making the resident an active participant in care, so that meaningful care plans can be developed.

The Medicaid Agency

- Lead the MDS Q Stakeholder Workgroup to:
  - Develop appropriate NF referral processes
  - Develop LCA processes
  - Identify funding sources for LCA activities
  - Work with ADPH Survey and Certification regarding documentation requirements
- Engage other agencies that may assist with NF transition
- Develop and implement the Alabama Community Transition Waiver
- Amend HCBS waivers to add transitional case management
- Amend the Targeted Case Management State Plan
- Develop MOU with LCAs
- Develop Data Sharing Agreements with NFs, ADPH, as needed

Nursing Facilities

- The NF must ask the resident about their goals for discharge at the time of the initial assessment (within 14 days after admission), quarterly and annually.
- The NFs will have assigned LCAs for their facilities to which they will refer these residents and must contact the LCA within 10 business days of a resident's "yes" response.
- The NF staff is expected to engage the resident in discharge planning and work with the appropriate agency to arrange for all of the necessary services for moving to the community as referenced in 42 CFR 483.20(l).

Local Contact Agencies (LCA)

- The LCAs will be responsible for contacting residents, discussing options, and assisting interested residents to return to the community. The LCA may also be referred to as entities that provide information and assistance or options counselors.

- The LCAs in many states are AAAs, Centers for Independent Living, ADRCs, waiver agencies, or other state-designated entity.

The Transition Process:
The State of Alabama has developed the following MDS Section-Q processes:

MDS Section Q Transition Planning: Phase I:
Step 1: Resident answers yes to Q0500 A and B
- NF MDS Coordinator notifies Discharge Planner or NF designee, of resident's response.
- If the resident already has a plan, no referral to LCA is needed.

Step 2: Discharge Planners Response
- Confirm the resident's desire to speak to someone about transition.
- Complete the *Nursing Home Discharge Planning Checklist.*
- Assess the resident's discharge potential within 180 days by developing a comprehensive care plan that includes measureable objectives and timetables to meet the resident's medical, nursing, and mental and psycho-social needs. The resident must have been in the NF 90 days.
- Develop a post-discharge plan of care with the participation of the resident and his or her family.
- Include as a part of the post-discharge plan the assessment of the continuing care needs to ensure that the needs of the individual will be met after discharge.
- Refer the resident to the LCA within 10 days after the resident responds "yes" and the *Nursing Home Discharge Planning Checklist is* completed.

Step 3: LCA Response to Referral
- The LCA must respond to the Discharge Planner within three working days of the referral.
- The LCA must initiate a face-to-face contact with the resident and representative, if applicable, within 15 business days.
- The LCA should complete the *Local Contact Agency Return to Community Assessment Tool* to determine the feasibility of the resident's return to the community. Nurses may also be involved in this process to assess the client's medical condition.

Step 4: LCA Role in Collaboration with Discharge Planner
- The LCA must record the referral date, nursing facility's name, contact person and phone numbers, and the resident's name and phone number. Include information about the resident's representative, when applicable.
- The LCA will discuss in detail what is needed by the resident to ensure a safe and successful transition.
- The LCA will evaluate each HCBS Waiver program to determine which waiver is appropriate for the resident.
- The LCA will discuss with the resident the service options available under each HCBS Waiver.
- The LCA will conduct at least three face-to-face visits during the 180 day transition process.
- If the resident wishes to proceed with a transition to the community, the LCA will work with the resident and the NF to develop a transition plan.
- The LCA will provide an *Options Counseling Visit Summary* to the resident and the NF Discharge Planner within three business days of the resident's assessment.

- For referrals to the EDW, SAIL, TAW, HIV/AIDS, and ID waivers and the PACE Program, the LCA will contact the Alabama Medicaid Agency, ACT Waiver Program Manager, within three business days of receipt of the *Options Counseling Visit Summary*.
- The Medicaid Agency ACT Waiver Program Manager will make the referral to the appropriate OA within two business days of receipt of the referral. The LCA and current OA, if there is a change in OA, will also be notified of the referral.
- If going to the ACT Waiver, the LCA will make a referral to the ACT Waiver Community Case Manager within three business days of the resident's assessment and completion of the *Options Counseling Visit Summary.*

<u>MDS Section Q Transition Planning: Phase II</u>

Step 1: Transition Process

- The resident and NF Discharge Planner or NF designee have been notified by the LCA that community transition is going to be pursued.

Step 2: LCA and Discharge Planners

- The LCA and Discharge Planner will coordinate contacts with agencies that may assist with the transition planning process. These agencies include:
  - Local Independent Living Centers
  - The HCBS Waiver Operating Agencies
  - Social Security Administration
  - Medicaid District Office
  - Local housing authorities, if applicable
  - Durable Medical Equipment providers
- The LCA may contact the ACT Waiver Program Manager for specific Medicaid eligibility or program coverage issues. Referrals will be made to other Medicaid staff as needed.

Step 3: LCA Transition Agency

- The LCA will work in cooperation with the resident, family, nursing facility, and community support service agencies toward the goal of transitioning to the community.

Step 4: The Planning Process

- Throughout the planning process, the *Local Contact Agency Return To Community Assessment* and the *Options Counseling Visit Summary* should be reevaluated to ensure that transition is still feasible.
- Prepare requests for home modifications, DME, use of the ACT Waiver Transitional Service, etc., during the last 60 days prior to the transition.

Step 5: Transition

- The resident successfully transitions to the community with needed supports.
- The HCBS Waiver Case Manager will monitor the individual's community care based upon the frequency described in the waiver document—typically every 30 days.

The Alabama Community Transition Waiver

The ACT Waiver will provide services to individuals with disabilities or long term illnesses who currently live in a nursing facility and who desire to transition to the home or community setting. A second target population would be individuals currently being served on one of Alabama's other HCBS waivers, whose condition is such that their current waiver is not meeting their needs and admission to an institution would be eminent if the ACT waiver was not an option to meet their needs in the community.

The ACT Waiver will also offer a consumer-directed option which will give individuals the opportunity to have greater involvement, control, and choice in identifying, accessing, and managing long term care services and community supports.

The consumer-directed option will be limited to the following services: personal care, homemaker, unskilled respite, companion services, and personal assistant service.

The ACT Waiver is approved to serve 200 individuals and has no age requirement. This waiver is operated by the Alabama Department of Rehabilitation Services and administered by the Alabama Medicaid Agency.

ACT Waiver Services:

- Community Case Management
- Transitional Assistance Services
- Personal Care
- Homemaker Services
- Adult Day Health
- Home Delivered Meals
- Skilled/Unskilled Respite
- Skilled Nursing
- Adult Companion Services
- Home Modifications
- Assistive Technology
- Personal Emergency Response Systems (PERS)
- Medical Equipment Supplies and Appliances
- Personal Assistant Service

The Program of All Inclusive Care for the Elderly

PACE provides community-based care and services to aged and disabled adults who would otherwise need nursing home level of care. This program was created as a way to allow the recipient, caregivers, and professional health care providers flexibility in addressing health care needs.

The PACE program is a capitated managed care benefit that features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with the needs of the participant.

The target group for PACE is recipients that meet the nursing home level of care, live in the community, a nursing home or at home.

PACE recipients must be 55 years of age and older, Medicare or Medicaid eligible or both and live in a designated PACE service area.

PACE will provide the following services:

- Primary Care (including doctor and nursing services)
- Hospital Care
- Medical Specialty Services
- Prescription Drugs
- Dentistry
- Nursing Home Care
- Personal Care
- Physical Therapy
- Adult Day Care
- Nutritional Counseling
- Laboratory/X-ray Services
- Social Services
- Transportation

There are several entities actively pursuing PACE Programs throughout the State of Alabama:

- Volunteers of America—Montgomery, Lowndes, Elmore, and Autauga counties
- Mercy Medical—Jefferson and Shelby counties
- Baptist Health Systems—Jefferson and surrounding counties

Transitional Case Management

The realization that many people with long-term care services and support needs can be safely cared for in the community setting and the requirements of the Supreme Court's Olmstead decision have increased states' commitment to transition residents of nursing facilities, intermediate care facilities for persons with intellectual disabilities, and other long-term care institutions to the community.

Successful transitions depend upon the ability to provide services and supports in the community that meet the needs of the persons transitioning.

Transitional Case Management is available to:

- Individuals that have been in the nursing facility for 90 days or more
- Individuals that are expected to move into the community within 180 days

To make Transitional Case Management available and community transition possible for institutionalized residents, Alabama Medicaid:

- Developed the Alabama Community Transition Waiver
- Offers Transitional Case Management in the home and community-based waivers
- Offers Transitional Case Management in the State Plan for Targeted Case Management
- Reserved waiver slots in the home and community-based waivers for individuals transitioning to the community

The following must be considered when determining the feasibility of community transitioning:

- Identify barriers to transitioning
- Ensure the availability of a comprehensive array of home and community-based services and supports
- Educate residents with the desire and potential for transition
- Collaborate with advocates and other stakeholders
- Implement care management/service coordination systems that support transition
- Address housing needs
- Provide flexible funding mechanisms

Additional Resources

Medicaid Resources

Much has been accomplished in the past several years through thoughtful planning, aggressive grant-seeking and responsiveness to the needs of Alabama's seniors and people with disabilities. We have also gathered many of the building supplies we need and are continuing to work on our final blueprint. The following are Medicaid resources developed as a result of grant initiatives and other requests for Medicaid research and proposal development:

- Single Point of Entry Study conducted by the Lewin Group
- Medicaid Buy-In Study conducted by the Lewin Group
- Long Term Care Needs Assessment conducted by UAB Center for Aging--*Charting the Course*
- Continuum of Care proposal developed by the Alabama Medicaid Agency/Long Term Care Division

Resources from Other State Agencies

The following is other initiatives or resources available within the State of Alabama:

- The Alabama Lifespan Respite Resource Network: *United Cerebral Palsy of Huntsville and Tennessee Valley, Inc. (UCP).* www.alabamarespite.org

- Alabama Connect is a statewide database of organizations which provide services to older adults and their family members. There is also a Self Assessment available to assist the consumer in determining the services they might need. www.alabamaconnect.gov

- Aging and Disability Resource Centers (ADRCs) provide a consumer-directed single point of entry into the continuum of care and social services system. The ADRC offers a statewide database of organizations that provide services to older adults, individuals with disabilities, and their family members. The two AAAs identified to serve as pilots for the ADRCs were the East Alabama Regional Planning and Development Commission region and the South Central Alabama Development Commission region. www.alabamaconnect.gov

- The Alabama Cares Program serves caregivers in five basic areas providing information, assistance, individual counseling, respite and supplemental services. The recipient receives caregiver assistance and provider training, case management, support groups, nutrition advice, homemaker services, and on a limited basis, emergency alarm response systems and transportation. ageline@adss.alabama.gov

- Through the Alabama REACH Intervention Project, ADSS has been able to reach out to an underserved and critical population of caregivers. The Virtual Dementia Tour training across the state, was designed to accomplish two goals: to develop and expand affordable, accessible, and culturally appropriate evidence-based services for Alzheimer's patients and families and to advance improvements in Alabama's system of care in LTC systems as well as home and community-based services. www.alabamaconnect.gov

- The Alabama Senior Medicare Patrol (SMP) is designed to educate Medicare beneficiaries and providers on how to detect and report healthcare fraud waste and abuse. SMP has received national recognition for the Medicare Protection Toolkit, which was developed for seniors to follow to safeguard their Medicare, as well as questions to ask when comparing new plans and to protect the most isolated beneficiaries who can be the most preyed upon individuals from healthcare scams. ageline@adss.alabama.gov

- Alabama SeniorRx: The Partnership for Medication Access program provides assistance for senior citizens with chronic medical conditions who have no prescription insurance coverage and limited financial means to apply for drug assistance provided by pharmaceutical manufacturers. ageline@adss.alabama.gov

- *Alabama Wellness Program* is open to all Alabamians age 55 and over regardless of income diagnosed with chronic diseases and focuses on wellness for the whole- person in six dimensions: emotional, intellectual, physical, social, spiritual and vocational health. The program is proving to be an effective way to promote successful aging. ageline@adss.alabama.gov

- *Constituent Services* are available to direct individuals who contact ADSS regarding services for seniors, to the appropriate person and/or agency best suited to assist them with common needs and concerns like financial assistance, prescription medication assistance, nutrition services and caregiver assistance. ageline@adss.alabama.gov

- *Engaging Aging – Senior Community Service Employment Program* is a federal funded, community service work-based training program for persons age 55 or older. The program's purpose is to provide useful community services and to help nurture individual economic self-sufficiency through training and placement into unsubsidized jobs. ageline@adss.alabama.gov

- *Legal Assistance* is a program that provides a statewide system of legal professionals assisting persons 60 years of age and older when personal legal problems arise. Assistance is given to the greatest social and economic need, low-income minority older individuals and older individuals who live in rural areas that need assistance with wills/estates, Medicaid, nursing home property ownership and health directives. ageline@adss.alabama.gov

- The *Long-Term Care Ombudsman* program identifies, investigates and resolves complaints made by, and on behalf of residents residing in long term care facilities. The program ensures the residents of their timely access to services and legal rights and protects their health, welfare, and safety. ageline@adss.alabama.gov

- *Nutrition: Congregate and Home-Delivered Meals* are one of the most successful community-based programs for seniors in America. Through strong dedication of state and local AAAs, nutrition service providers, volunteers and private sector, more than 4 million congregate meals are provided in senior centers and home-delivered meals every year. ageline@adss.alabama.gov

- *State Health Insurance Assistance Program (SHIP*) provides counselors in order to raise awareness to over 780,000 Medicare beneficiaries about the importance of accessing SHIP services. SHIP made it a top priority to reach out to rural and hard-to-reach areas of the state and assist beneficiaries who are on a limited income and may qualify for extra benefits. ageline@adss.alabama.gov

- The *United We Ride Grant* is designed to serve both urban and rural citizens in a two-county region. The pilot project was implemented and completed successfully in the Lee-Russell Council of Governments (LRCOG) region. The State's mission is to provide an easily accessible and coordinated transportation system that addresses the needs of older adults, people with disabilities, and individuals with lower income. ageline@adss.alabama.gov

- *Alabama's Early Intervention System (AEIS)* coordinates services statewide for infants and toddlers with disabilities and developmental delays from birth to age three, preparing them and their families for the transition to the State Department of Education's preschool program for three-to-five year olds or other community programs. Financial and Technical support is available to the more than 60 community programs that provide early intervention services and expertise to eligible families. www.rehab.state.al.us

- *Children's Rehabilitation Service (CRS)* provides services to children with special health-care needs from birth to age 21 and families. www.rehab.state.al.us

- *Vocational Rehabilitation Service (VRS)* provides rehabilitation, education and employment related services to 47,083 adolescents and adults with disabilities through long-standing partnerships with local school systems, colleges and universities, junior colleges, vocational technical schools and community rehabilitation programs. VRS also provides more than 6,800 disability management and employee placement services to Alabama businesses each year.

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