# Area Plan October 2025-September 2029

Area Agencies on Aging were formally established in 1973

The Administration on Community Living, which oversees the Older Americans Act at the national level, requires that each individual Area Agency on Aging submit a plan for how they will use the Older Americans Act funds and how they will work on the initiatives set forth by the Administration on Aging to its respective State department.

**Northeast Kingdom Council on Aging, Inc.**

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**(802) 748-5182**

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**ATTACHMENT B**

**Verification of Intent**

The NEKCOA ____ Area Agency on Aging's Area Plan is hereby submitted for the period October 1, 2025, through September 30, 2029. It includes all assurances and plans to be followed by the submitting agency under provisions of the Older Americans Act and the Area Plan Instructions. The Area Agency on Aging identified shall assume full responsibility to develop and administer the plan in accordance with all requirements of the Act and related State policy. The Area Agency on Aging assumes major responsibility to develop and administer the Area Plan for a comprehensive and coordinated system of services and to serve as the advocate and focal point for older people in the planning and service area.

The Area Plan was developed in accordance with all rules and regulations specified under the Older Americans Act and will be submitted to the Department of Disabilities, Aging and Independent Living.

Signatures below verify the intention to comply with all Older Americans Act and State of Vermont assurances.

Date 8/1/25 (signed) Meg Burnett
Area Agency on Agency Director

Date 8/1/2025 (signed) Ross Farnsworth
President, Board of Directors

The Area Agency on Aging Advisory Council has had the opportunity to review and comment on the Area Plan.

Date 8/1/2025 (signed) Kathleen E. Joslin
Chairperson, Area Agency on Aging Advisory Council

Date Approved

Commissioner, Department of Disabilities, Aging and Independent

# Mission Statement

**The Northeast Kingdom Council on Aging**

**Our Mission** is to make N.E. Vermont the best place in which to grow old with dignity, respect and independence.
**Our Vision** is to be known as a respected partner in the community for developing and delivering quality services to older adults, people with disabilities and family caregivers.
**Our Values**:

- We are **committed to client self-determination** in a context that includes trust, respect and support for both the clients and their families/caregivers.
- We value our **communities** because they are close-knit, strong and caring systems of grassroots support.
- We value **cultural differences** and independence.
- We believe in **supportive work relationships** based on trust, respect and honest communication.
- We value a healthy, safe, respectful and **supportive working environment** that is dedicated to keeping employees well informed to better serve our clients.
- We value our **employees** by providing a positive mix of benefits and pay.
- We are committed to respectful and positive **collaboration** with other **service providers**.

## Section A: Executive Summary

The Northeast Kingdom is an area where both poverty and isolation due to rurality of the region create unique challenges. To that end we find the need to ensure that we are providing access to information and services thru diverse means. Reaching out to where people go (town clerks, general stores, post office, doctors' offices, libraries) and ensuring that information is readily available is one way to ensure that those with greatest need are provided with the opportunity to secure assistance. The geographic challenges result in greater social need to remain connected in the communities.

This area plan presents a unique set of experiences that lead us into the next area plan. The NEK is a unique region as it is the most rural part of our state and the smallest in terms of population. The result is often a lack of adjusted resources to meet the needs of the region in terms of statewide allocation of funding to take those factors into account. This plan also is the first one that incorporates the impact of COVID as we work to develop more integrated resources for those in our communities. That was and is a valuable lesson learned from the pandemic.

This plan is developed in a truly collaborative approach of gaining input and insights from those we serve, our community at large, and other nonprofits that we partner with in our region. As we work to be more efficient and mindful of limited resources, we work to reduce duplication of services, increase community awareness, and development of resources that provide for meeting needs.

Access and Information were raised as an issue in the needs assessment. In an effort to adress this we have joined with the local hospital, medical practices, mental health agency, department of health and community action to have an Organized Health Care Arrangement (OCHA) agreement that helps to coordinate services for clients and offer opportunities for increased collaboration through team-based care efforts effective May of 2025. This allows for us to be informed and inform of changes regarding clients occurring so that planning and coordination of services can be achieved, thus helping to reduce the clients who "fall thru the cracks". Additionally, because of the needs assessment process we have developed a "transitions coordinator role" which is working to expedite community partner referrals as the agency is the primary case management agency thru the conflict free case management requirement from Center for Medicare Services (CMS). This position has been key in moving referrals through the helpline system with a closed loop referral process ensuring that communication is effective in handling unique needs of the consumer and with improved timely responses. This also provides an opportunity to educate referral sources regarding appropriate referrals to our agency as well as other sources such as Adult Protective Services (APS), Home care, etc. As many are referred for services, this position helps to facilitate referrals that are accurately referred to appropriate services. We see this as a critical need in addressing the concern raised in the needs assessment.

Additionally, we are actively working with community partners utilizing a team-based care approach ensuring that duplication of services is minimized. This team approach encourages service coordination.

The need to provide continuous information and awareness of service options is a significant need in the world of misinformation and misleading information. We find the need for continued sharing of information key to responding to the needs assessment concerns raised around this issue.

Tech for Today is a volunteer grant that we received from Money Follows the Person program for a two-year grant and due to the success of the model has now entered its fourth year of funding. This program uses a part time staff person who coordinates volunteers that are knowledgeable of computer/cell phone/internet usage and problem solving. It continues to be a program where demand is steady as more people seek internet for exploring options to meet their needs and use of application systems that require internet usage. While the program works to educate and support smart technology usage, it is a war against the scammers sending false invoices, romance scams and other misleading entrapments that consumers need education to avoid. It has also provided a means to supply items needed such as phones and Chromebooks.

Housing was a significant issue in the needs assessment. As a result we began to work with Home Share VT as a program that works as an alternative to the housing crisis that we see in the NEK and beyond. We were fortunate to receive an opportunity through the legislature for 25/26 fiscal year to partially fund a case manager position to bring Home Share to the NEK and have begun to develop this resource. Initial work was so very successful as the program spread into the NEK that the impetus for the request for funding showed the need and desire for people to participate in this program.

Wellness options were raised as a key area to increase awareness throughout the communities. This work has been in existence for over 20 years and has a robust network of options such as Arthritis Foundation Exercise Program, Falls Prevention Tai Chi and several non-evidence-based offerings such as Chair Yoga, Line Dancing, and Golden Ball Tai Chi. This effort results in 47 classes per week are offered throughout the NEK. The VT Dept of Health through a grant has helped to increase the outreach for both volunteer leaders and participants. These programs are all led by volunteer leaders which present its own challenge in supporting them and further developing programs to meet needs in the far reaches of our region. We will incorporate increased communication for ease of access to connecting people to classes.

Nutrition security continues to be raised as a need to provide and inform about healthy meals and nutritional choices. This home delivered meal program runs through a large volunteer contingent, and we contract with 14 sites that comprise both home delivered and congregate meals. The NEK is fortunate to be the initial site for Veggie Van Go, Church meals, and food pantries such as the refrigerator program that offers an anonymous way to secure food at a number of sites without the stigma of needing food. Our work with community partners and contractors continues to see this program develop healthier options and resources for those who reside in our area.

From a funding perspective, we face challenges as we continue to be asked to provide services to a growing population. For 6 years we have faced level funding from the OAA that equates to a reduction in funding when one considers increased cost of living. We have worked tirelessly to streamline our work, be more efficient, respond to increased compliance demands and at the same time respond to an increased aging population in the state. The nutrition program comprises about 45% of our spending and relies on a contract system with local meal providers who experience increased costs. While global commitments funds have assisted in raising reimbursement rates, sustainability is a challenge to maintain this higher level of funding. The agency had been working on a several year project to bring meal costs across the board to equality, we had been hampered by level funding. The Global

Commitments funds allowed us to equalize and increase rates across the board to our contracted providers.

The Older Americans act relies heavily on volunteer network to support the home delivered meals, community meals, and wellness programs. While this is a cost-effective strategy, the means to keep volunteers in place requires a substantial amount of effort in the constant cycle of volunteerism. As the cost of living continues to rise, the increased cost needed for many in their own homes becomes burdensome and a challenge to maintain it, leaving many living in dilapidated housing stock. Poverty has a significant impact with relation to upkeep of housing and resources for repair/replacement are quite limited. Additionally, as the state has focused efforts on the ability to "age in place", the resources to develop staffing needs falls far short of the need thus leaving people without the full complement of staffing needed to remain in the community.

Good old Yankee pride can also be a hindrance and challenge for those who are facing increased isolation and poverty to reach out for assistance. To this end, we work to use a communication strategy that provides presentations, postering, social media, newspapers, and radio to get the word out about resources.

Conflict free case management has been both an accomplishment and a challenge for the agency. Being the smallest agency of the area agencies on aging translates to less funding with the same expectations that are needed to meet the standards set forth by the state and federal government. As with any large systemic change, there is an adjustment period and relationship building to ensure that people are being served using a person-centered approach.

We would be remiss not to mention the challenges brought on by the efforts in Washington to downsize government through elimination of programs and staffing that support them. The amount of news that creates heightened anxiety for those struggling to survive is palpable and causes additional worry on an already complex system. This is not only true for the consumers of services but staff who are repeatedly dealing with consumer anxiety.

## Section B: Needs Assessment

This area plan explores the future needs of Northeast Kingdom residents as we work to support their aging well in our local communities with dignity and respect. To gain perspective, the population of this tri-county region is estimated to have 22% of its residents over the age of 60(US Census Bureau 2023). Additionally, the fact that we are a large significantly rural section of the state adds to the complexity of need in an area that spans the geographic equivalent of the state of Rhode Island. We also border New Hampshire and Canada which add to the challenges faced by those who live in our region as the inter-collaborative process has been challenging with staffing turnover and thus a need to re-educate those partners outside of our service region. Given the rural territory we cover, many travel to those services outside of our service region.

To help inform us of needs, challenges and opportunities, we participated in two needs assessments this year.

**Community Health Needs Assessment:**

Our work with our local NEK Prosper accountable health initiative found us seeking to work with community partners in an effort to gain insights without overwhelming the consumer with multiple surveys. The Northeast Kingdom Coordinated a Community Health Needs Assessment (CHNA) Steering Committee formed in January 2024 and led this inaugural CHNA approach. The participating member organizations include NVRH, North Country Hospital, Northeast Kingdom Human Services, Northern Counties Health Care, Northeast Kingdom Community Action, Northeast Kingdom Council on Aging, and the Vermont Department of Health. Between February and May, extensive secondary data analysis occurred to better inform the issues in our region. While the timing took longer, that was largely driven by the work of the committee coming to clear work ensuring that a relevant and thoughtful approach to secondary data moved us forward in focusing the survey. Primary data collection approaches were developed, and a survey was developed and implemented between April and August. Final data analysis and development of the HAS-level report occurred between August and September 2024. In addition to further exploring elder issues two focus groups occurred during that time. This project yielded close to 500 surveys.

**DAIL Statewide needs assessment:**

This needs assessment was conducted via DAIL, which helped to provide a more focused and statewide assessment of need around the needs of older residents and caregivers. We participated by sending the survey out to participants and caregivers. The responses from both assessments highlighted the needs being experienced by consumers in our region.

## Food Security and nutrition:

30% of older adults in the NEK reported concerns around food insecurity as rerpoted by Feeding America.(2022) and County Health Rankings (2022). Many rely on social support such as home delivered, congregate meals and community food pantries. Limited access to healthy and affordable food was a finding of the community needs assessment. This was also connected to cost of living and lack of awareness of resources. In our region, where there are limited options for food stores, this issue is even more concerning. The SNAP program, while a valuable resource, is fraught with bureaucracy that for many is untenable and leaves them dropping the program. This occurs as a result of the demands for documentation that leave people making a

choice not to participate. We are fortunate to have the resource of the VTFoodbank, and their veggie van go program as well as commodity programs. In the NEK, a movement to have refrigerators with food in communities began several years ago, which provided an unbiased option for those with food insecurity to access food. In St. Johnsbury, the community has come together to provide free community meals at least 4 nights per week thru the local churches and while Newport does have some meal options, not to the extent offered in St. Johnsbury. The highlighted need for increasing awareness within our community of resources to address social drivers of health is seen in both assessments. Awareness of 3sqVt, Commodities food program and other resources to meet food scarcity needs was a key component of the findings.

**Action Steps for NEKCOA:**

- Educate and inform meal sites to produce therapeutic and healthy meals.
- Partner with NEKProsper to focus education to the public around food security resources in the region as well as a public education plan to help inform health benefits of enhanced nutritional choices.

## Health and wellness related challenges:

Continued challenges by providers in our region to staff professional level doctors, nurses, and other professionals' results in challenges for those attempting to access treatment. The current wait list for a neurology appt. with both memory centers (Dartmouth and UVM) is over 4 months and is an hour and a half drive one way for both locations. Given the challenges of health care and the provider shortage there are many who end up needing hospitalization due to putting off or not following through with care. This coupled with a workforce shortage for in-home care providers results in many struggling to receive care or giving up. This coupled with higher rates of cardiovascular disease, diabetes, COPD and obesity in our region make this a significant issue.

**Action steps for NEKCOA:**

- Expand the use of team-based care to develop a collaborative approach to the client needs helping to reduce obstacles for aging in place.
- Increase public awareness campaigns around health and well-being topics to better inform of services and resources such as wellness classes.
- Further develop the use of OCHA for a more informed ability to respond to changing needs of clients.

Access to care and affordability in the areas of mental health and dental care were also highlighted as needs to be addressed.

**Action steps for NEKCOA:**

- Develop material to disseminate resources for both mental health and dental care to better inform of options available.
- Advocate for increased services around mental health as the Eldercare Clinician program has not had a funding increase in many years.
- Advocate for improved access to dental services in the region.

## Transportation challenges:

Transportation in our region is served by RCT, and funding is provided through the federal and state government. While we work with RCT, we see a monthly budget from the federal and state funds that is often surpassed by requests from riders for medical appointments and for grocery shopping in line with funding constraints is limited to two times per month. While Medicaid provides transportation, those who do not have Medicaid are constricted to the federal/state funding availability. Given the limited funding through the state/federal system it remains a challenge that we do not have resources to help support those seeking to lessen social isolation by participating in community activities. We are inspired by the 'on-demand' service developing for those in specific areas and hope that it will be further developed to expand beyond the more densely populated area of Newport where it is being piloted.

**Action steps for NEKCOA**

- Advocacy focusing on informing legislature regarding needs to increase this resource through the use of options such as the on-demand service.
- Explore volunteer opportunities with RCT to increase number of volunteer drivers available.

## Caregiving support:

Increased demand for families and communities to provide support for those living at home creates quite a challenge, especially as caregivers have limited options for care. With significant care needs of a growing population of people experiencing dementia/Alzheimer's this creates a challenge in efforts to both educate and support caregivers. 53% of those responding provided care for more than 4 years; 70% of caregivers were above age 60. The respite program has constraints that occur due to income limits, limited assistance, and limited options for caregiving support by trained individuals.

**Action steps for NEKCOA:**

- We will develop a comprehensive communications plan to raise awareness of services and resources in the community to raise an inclusive awareness that meets the needs of those of greatest need.
- We will continue to increase awareness of Trualta and as a strategy to help inform of options for self-care and caregiving learning/problem solving in the caregiving role.
- Continue to expand the volunteer respite program as an alternate source of caregiver support.

## Limited broadband:

Limited broadband and the cost for it is a challenge for those seeking to use the internet as a means of connecting with others, learning new things and accessing services in general. Through an MFP pilot program, we have developed a model using volunteers that has been successful in supporting this, however it does not provide financial support to pay for internet services. The increased challenges faced by elders with the manipulation of information, pressured phone calls, and relentless false advertising raise another challenge for older residents is concerning.

**Action steps for NEKCOA:**

- Explore means to continue pilot Tech for Today program.
- Explore funding options to support broadband access.
- Promote information on safe use of computers and cell phones using public outreach tools.
- Inform the public of scams to reduce the number of people falling for them by increasing awareness of the state's attorney information on current scams.

## Access to services:

In both needs assessments not knowing where to turn for assistance or resources was a barrier which then limits people's ability to access benefit programs.

**Action steps for NEKCOA:**

- Develop a communications strategy plan to better inform of the helpline and options at the community level for assistance through our focal points. This plan will include multiple avenues of communication.

## Housing:

The lack of affordable options leads to many older residents being forced to remain in homes that need routine maintenance often left deferred due to income/resources. We continue to see a significant wait list for those seeking alternatives.

**Action steps for NEKCOA:**

- Develop HomeShare VT in the NEK region to raise another option for those facing the housing crisis.
- Participate in community activities to further develop housing resources in our region through advocacy and raise awareness of needs.

**Section C: - Community Focal Points:**

We continue to see the need for a multi-faceted approach to informing the public of resources and options for aging well in their communities. While we work with focal points in our region, the limited resources and stagnant funding result in smaller meal sites that are not able to provide full service. We provide presentations to each meal partner and to other outside community groups as requested. As the Older Americans Act emerged long before computers and 800-numbers we work to ensure that we are meeting the needs thru a collaborative effort. Our helpline continues to manage calls for those seeking the privacy of a phone conversation or an in-person meeting place at their convenience (for some, that is in our office). Limited meal options in parts of our region require us to expand our outreach to town offices, community-led meals, and other community-focused opportunities to share information. Additionally, we find a need to be where people go and have worked to be a presence within the health care entities in our region. A collaboration with Northern Counties Healthcare provides us with an opportunity to work in their offices in both Hardwick and Island Pond which are a distance from our offices. From the success of those efforts, we have been invited to now provide staffing for the Concord and Danville Health Centers to meet with clients, consult on team-based care and collaborate with care coordinators. We have a staff member present at each of the 4 sites once per week to meet with clients, consult with care team members, or participate in team-based care conferencing. Additionally, we have found that tabling at public events and presentations to community groups also serve to disseminate information regarding service options.

Focal Point Name: **Northern Counties Health Care: Concord Health Center**
Focal Point Address: **201 E Main St, Concord, VT 05824**
Key Agency Staff at the Focal Point: **Kim Rivard**
Key Staff Contact Information: **800-642-5119**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**We staff the site 1 full day per week.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Information and Referral<br>Care Coordination<br>Options Counseling<br>Health Insurance Support | |

Focal Point Name: **Northern Counties Health Care: Hardwick Area Health Center**
Focal Point Address: **4 Slapp HI, Hardwick, VT 05843**
Key Agency Staff at the Focal Point: **Kim Rivard**
Key Staff Contact Information: **800-642-5119**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**We staff the site 1 full day per week.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Information and Referral<br>Care Coordination<br>Options Counseling<br>Health Insurance Support | |

Focal Point Name: **Northern Counties Health Care: Island Pond Health & Dental Center**
Focal Point Address: **82 Maple St, Island Pond, VT 05846**
Key Agency Staff at the Focal Point: **Kim Rivard**
Key Staff Contact Information: **800-642-5119**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**We staff the Site 1 full day per week.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Information Referral<br>Care Coordination<br>Options Counseling<br>Health Insurance Support | |

Focal Point Name: **Northern Counties Health Care: Danville Health Center**
Focal Point Address: **26 Cedar Ln, Danville, VT 0528**
Key Agency Staff at the Focal Point: **Kim Rivard**
Key Staff Contact Information: **800-642-5119**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**We staff the site 1 full day per week.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Information Referral<br>Care Coordination<br>Options Counseling<br>Health Insurance Support | |

Focal Point Name: **Lyndon Area Senior Meal Center**
Focal Point Address: **76 Depot St. Lyndonville, 05851**
Key Agency Staff at the Focal Point: **Cindy Santaw- Brown**
Key Staff Contact Information: **802-626-8700**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**We provide information which is distributed at the site and do presentations on services 2 times during the year and additional times when requested. Brochures and material are present at the site and site staff are trained in the referral process**.

| OAA Programs | Non-OAA Programs |
|---|---|
| Congo meals<br>HDM<br>Presentations of services and resources | Bingo, music<br>Blood Pressure checks |

Focal Point Name: **Good Living Senior Center**
Focal Point Address: **1207 Main St. St. Johnsbury, VT 05819**
Key Agency Staff at the Focal Point: **Vicki Giella (board chair)**
Key Staff Contact Information: **802-748-8470**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**All wellness program leaders are trained in referral process and how to contact I&R. We additionally provide presentations on our services as requested.**

| OAA Programs | Non-OAA Programs |
|---|---|
| AFEP classes<br>Bone Builder classes<br>Presentations of services and resources | Music<br>Bingo<br>Golden Ball Tai Chi<br>Game days with local schools |

Focal Point Name: **St. Johnsbury Nutritional Center**
Focal Point Address: **St. J House 1207 Main St. St. Johnsbury, VT 05819**
Key Agency Staff at the Focal Point: **Diane Coburn, Manager**
Key Staff Contact Information: **802-748-5467**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**Biannual presentations and additional presentations upon request.**

| OAA Programs | Non-OAA Programs |
|---|---|
| HDM<br>Presentations of services and resource<br>Congo meals | |

Focal Point Name: **South Ryegate Senior Meals**
Focal Point Address: **Church St., South Ryegate, VT**
Key Agency Staff at the Focal Point: **Mary Lou Boyce**
Key Staff Contact Information: **802-584-3727**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**Biannual presentations and additional presentations upon request.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Congo meals<br>HDM<br>Presentations of services and resource | Music |

Focal Point Name: **W. Barnet Senior Meal Site**
Focal Point Address: **W. Barnet Presbyterian Church. W. Main St, W. Barnet, VT 05821**
Key Agency Staff at the Focal Point: **Jean Warner, Manager.**
Key Staff Contact Information: **802-748-2565**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process**.

| OAA Programs | Non-OAA Programs |
|---|---|
| Congo Meals<br>HDM<br>Presentations of services and resources | Music |

Focal Point Name: **Burke Senior Meal Program**
Focal Point Address: **Community Building. 212 School St. W. Burke, VT 05871**
Key Agency Staff at the Focal Point: **Wendy Bean, SM. Lynn Welch, Board Chair.**
Key Staff Contact Information: **802-467-3423**
How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Congo meals<br>HDM<br>Presentations of services and resources | Music, cards<br>Line dancing<br>Wii Bowling |

**Essex County:**

Focal Point Name: **Lunenburg, Gilman & Concord Sr. Center.**

Focal Point Address: **19 Parrish St. Gilman, VT 05904**

Key Agency Staff at the Focal Point: **Pam Kathan, SM. Sharon Eaton, Board Pres.**

Key Staff Contact Information: **802-892-5300**

How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Congo meals<br>HDM<br>Presentations of services and resource | Bingo<br>Book club |

Focal Point Name: **Island Pond Community Services**

Focal Point Address: **Sunrise Senior Housing. 94 main St., Island Pond, VT 05846**

Key Agency Staff at the Focal Point: **Melinda Gervais- Lamoureux, Manager.**

Key Staff Contact Information: **082-723-6130**

How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Congo meals<br>HDM<br>wellness classes<br>Presentations of services and resources | Music<br>Cards, Bingo<br>Crafts |

**Orleans County:**

Focal Point Name: **Barton Areas Sr. Sys (BASSI) and Glover Senior Meals**

Focal Point Address: **Old Town Hall. Rte. 16, Glover, VT 05839**

Key Agency Staff at the Focal Point: **Cathy Reinstein, SM**; **Donna Greenwood, Chef**

Key Staff Contact Information: **(802) 525-3134; (802) 624-3658**

How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Congo meals<br>HDM meals<br>Presentations of services and resource | Music<br>Cards<br>Bingo, Crafts |
| | |

Focal Point Name: **Newport Senior Center Forever Young Club**

Focal Point Address: **222 Main St. Newport, VT 05855**

Key Agency Staff at the Focal Point: **Ethel Searles**

Key Staff Contact Information: **082-334-6029**

How does the AAA work to ensure that OAA services are accessible to the public from the focal point?

**Biannual presentations and additional presentations upon request. Brochures and material are present at the site and site staff are trained in the referral process.**

| OAA Programs | Non-OAA Programs |
|---|---|
| Wellness classes<br>Presentations of services and resource | Drop-in center<br>Bingo, Cards<br>Intergenerational activities<br>Hot meals |

## Section D: Goals, Objectives & Strategies with RBA report Cards:

## Title III: Community Planning and Systems Development

**Goal/Outcome:** To increase work within the NEK in collaborating and coordinating services in the interest of greater outreach and education as to services and resources available to older residents of the NEK**.**

**Action Steps:**

1. Develop a communications strategy plan to better inform of the helpline and options at the community level for assistance through our focal points. This plan will include multiple avenues of communication.
2. Continue to train and integrate team-based care in approach to work with clients and those that serve their needs in the community.

## RBA Report cards:

## Goal 1: Title III-B: Information & Assistance

**Goal/Outcome:** Information and referral services to improve, expand, and innovate outreach to the community will be a focus to disseminate information more effectively.

**Who does the program serve?** Older Vermonters, family members, caregivers who seek information around resources and program services to meet their needs.

**What does this program do?** This program provides helpline and walk-in information to those seeking support in exploring services and programs to meet their needs for aging well in the community.

**Headline Performance measure:**

1. # of consumers contacting the helpline because of increased outreach efforts. The baseline graph to be developed in the first reporting period.

**Headline Performance measure:**

2. 80% of those surveyed after a helpline interaction will report increased awareness of options available to them. The baseline graph will be developed in the first reporting period.

**Story behind the baseline:** Having access to information that supports consumers connecting with resources, services and support is essential in helping to ensure aging in place. Through the needs assessment process, access to information and unbiased assistance is a significant need. This baseline will work to increase our efforts to better inform consumers of services, resources and support.

**What works:** social media, newspaper articles, and newsletters help to inform options for gaining access and information for services needed. Coordinated information shared with community partners for their own publications.

**Partners:** Community partners such as accountable care networks we participate in will ensure that we can develop a coordinated effort to inform.

**Action plan:** Increase awareness of the helpline and options counseling to help people be aware of resources. Through this we will increase our efforts year over year.

## Goal 2: Title III-B: Case Management Person-Centered Planning Common Goal

**Goal/Outcome:** OAA Case management clients will report health related social need (HRSN) improvements related to at least one social/health related goal in their person-centered plan.

**Who does the program serve?** This program serves individuals who are needing case management assistance to ensure success in fulfilling their person-centered planning goals.

**What does this program do?** Works with the individual to develop a plan for aging in place and take actions to support the client in achieving their goals. This is done through a collaborative process of advocacy, assessment, planning and action.

**Headline Performance Measures:**

**1.** % and # of clients who establish at least one social/health related goal on their person-centered plan.

Baseline graph will be developed in first reporting cycle.

**2.** % and # of clients who *achieve* at least one social/health related goal on their person-centered plan. Establish stretch targets in Years 2 and 3 compared to baseline in year 1.

**3.** # of clients' reporting received support to address their goals. Baseline will be established in first cycle of reporting.

**Story behind the baseline:** Case management should focus on person-centered goals, ensuring that clients' choices and preferences are at the core of the care process. Clients should be fully informed about all available care options, enabling them to make empowered decisions that align with their values and goals. Supporting clients in maintaining control over their health decisions is crucial to helping them remain engaged. As individuals' needs change, navigating the complexities of care can become more challenging. Case managers must work closely with clients to assess their evolving needs and provide support, all while respecting the client's goals and maintaining their autonomy. Building and nurturing a strong, trusting relationship between case managers and clients is vital to ensure that care is tailored to meet the individual's unique needs, ultimately improving their quality of life.

**What works:** The person-centered planning process involves a degree of skill on the part of the Case Manager to synthesize the information into a meaningful document that can be the foundation of the work for the care team.

**Partners:** We are working with community partners to establish team-based care approach to reduce redundancy of services and efficiently meet the client's needs most effectively based on their goals.

**Action Plan:** Train staff to increase the comfort and assistance in developing meaningful plans with clients. Ensure that the team-based care approach works to disseminate coordinated information and supports to help the client attain their goals.

## Goal 3: Title III-C Nutrition: Home Delivered Meals

**Goal/Outcome:** Clients receiving HDM therapeutic meals will report an improvement in their health condition for which the medically tailored /therapeutic meals address.

**Who does the program serve:** The HDM program serves those who meet the stated criteria to receive home delivered meals. Any person is eligible who is age 60 or over and is **unable** to obtain or prepare meals on a temporary or permanent basis due to a physical, mental, or cognitive condition that requires assistance to leave home.

**What does the program do:** Provides 1/3 of the daily rda for clients in their home and a safety check completed by the meal's driver.

**Headline Performance Measures**:

1. # of clients receiving therapeutic meals. Baseline data will be developed from first reporting cycle.

**2.** % of clients who report they have benefited from these meals. Establish stretch goals in Years 2 and 3.

**3.** # of sites that demonstrate improved menu focus on healthy options

**Story behind the baseline:** Approximately 75% of American's dietary intake is insufficient in fruits, vegetables, and dairy. Furthermore, 63% of Americans exceed the recommended limit for added sugars, 77% surpass the limit for saturated fats, and 90% exceed the Chronic Disease Reduction limits for sodium intake as reported by Feeding America (2022) and County Health Rankings (2022) Factors such as diminished appetite, a reduced sense of taste and smell, difficulty chewing or swallowing, and mobility loss contribute significantly to malnutrition in older adults. For many seniors, the issue is not overeating but failing to consume sufficient nutrients at a time when proper nutrition is more crucial than ever. A growing body of research supports the positive impact of home-delivered meals on the health and well-being of homebound older adults. This research serves as the foundation for exploring specialized interventions designed to address the unique medical and nutritional needs of individuals living with chronic illnesses, regardless of age—known as therapeutic meal options. Our goal is to expand our therapeutic meal offerings to continue supporting clients with chronic illnesses. Research has shown that such meals can help individuals with current medical conditions maintain or even improve their health. Additionally, that expansion requires us to increase awareness of healthy options for meal sites in terms of meal preparation/offerings.

**What works:** Teaching people that there are healthier options available to assist with their ability to manage their health and wellbeing.

**Partners**: We will work with all meal providers, our RD and staff to increase awareness and options to improve hdm's.

**Action Plan:** We will develop training for meal sites as well as educational materials that support healthier diet choices through our monthly home-delivered meals newsletter. Through measurement of the RBA goals, we will reevaluate and adjust our strategy to improve successful outcomes.

## Goal 4: Title III-D Health Promotion and Disease Prevention

**Goal/Outcome:** Improved wellness program impact on health and wellbeing. Increased Percentage and number of OAA Health Promotion Program participants that join, complete an evidence-based wellness program and set a measurable goal.

**WHO does the program serve?** Community members (60+) who want to participate in evidence-based wellness programs:

**WHAT do the programs do?** The benefits of wellness programs include social and physical health which have a positive impact in reducing the likelihood of falls, increasing balance and strength while supporting the ability to maintain the participant's independence and social health.

**Headline Performance Measures**:

**1.** Total # of clients who participate and complete annually in Health Promotion evidence-based programming. Baseline graph will be developed in first reporting cycle.

**2.** # of clients that set a measurable goal. Baseline graph will be developed in first reporting cycle.

**3.** Target 5-10% increase in client participation year over year.

**Story behind the baseline:** While a number of OAA clients have expressed interest in, and do participate in evidence-based programs, a gap remains in terms of increasing engagement, program completion, and specific goal setting. Many clients start the programs but do not finish, and fewer still set measurable goals that are tracked over time. Several factors may contribute to this, including limited awareness of available programs, difficulty in accessing resources, and, for some, a lack of motivation or understanding of how to set achievable health and wellness goals. There may also be an underlying issue of inconsistent communication with participants regarding program benefits, as well as barriers like transportation challenges, cognitive limitations, and a lack of confidence in using technology for virtual program participation.

**What works:** Offering free accessible classes to those who choose to participate. Increased advertising the benefits and options also helps people to understand what options are available.

**Partners**: Volunteer leaders and participants are the best word of mouth advocates to share with the community the benefits. Additionally, we will promote the classes through distribution of schedules and highlighting the benefits of classes available through community partners.

**Action plan:** We will work with the participants and program to establish goals through an initial survey of people as they begin the program. Additionally, we will work to increase awareness of this community resource option through outreach and advertising both with community partners and the public at large.

## Goal 5: Title III-E National Family Caregiver Supports

**Goal/Outcome:** Unpaid Caregivers will have improved access to information, support and services.

**WHO does the program serve:** Any caregiver in the NEK who requests support, resources and education around caregiving.

**What does the program do**? provides a meaningful opportunity to focus on wellness and socialization with peers.

**Headline Performance Measures:**

**1.** # of caregivers who access information and resources as evaluated by internal tracking systems/database including TCARE. Establish stretch targets in Years 2 and 3 compared to baseline in Year 1.

**2.** # of public engagement /outreach activities provided to the public that contain information and resources available to caregivers. Establish stretch targets in Years 2 and 3 compared to baseline in Year 1.

**Story behind the baseline:** National data indicates that many caregivers face challenges in accessing information, support, and services. Approximately 39.8 million Americans, or 16.6% of the population, provide care to adults with disabilities or illnesses as reported by the Alzheimer's Association. While caregivers provide invaluable support to older adults and individuals with disabilities, many report challenges in accessing the information, resources, and services they need to effectively care for their loved ones. Feedback from caregivers indicates a gap in available resources, insufficient guidance on available services, and difficulty navigating complex systems of care. As a result, caregivers may feel overwhelmed, unsupported, and unsure of where to turn for assistance. By addressing the barriers caregivers face in accessing necessary information and support, we aim to empower caregivers with the tools and resources they need to provide high-quality care while reducing their stress and isolation. This will improve the caregiver's well-being and enhance the care they can provide for their loved ones.

**What works:** Continued communication to community partners and individuals allows for the promotion of discussions and resources. We believe that access and increased awareness helps achieve the ability to participate and benefit from focus on well-being. We believe that increased communication of these programs will increase participation /awareness of resources available.

**Partners:** Direct work with community partners (hospitals, doctors, home health, mental health) to increase awareness of this option is key to expanding the use of these programs.

**Action plan**: We will increase the work with participants to mindfully set goals and achieve positive results.

## Goal 6: Title VII: Prevention of Elder Abuse, Neglect and Exploitation.

**Goal/Outcome**: Staff and community partners will report an improved knowledge of abuse and exploitation and make appropriate referrals**.** Area on Agencies will use Title III and Title VII funding from the OAA to provide support to our communities and older residents for the services that NEKCOA coordinates.

**WHO does the program serve?** Individuals 60 years and older.

**WHAT does the program do?**

- Identifies if an individual is being exploited or feels unsafe,
- Connect staff and individuals to resources
- Uses a Person-Centered approach in monitoring and assessing clients
- Implements additional staff training to identify abuse and/or exploitation.
- Provides resources to evaluate the safety of an individual in their setting of choice.
- Promote public awareness of abuse, neglect and exploitation.

**Headline Performance Measures:**

**1.** # of referrals made to APS from clients who report or NEKCOA suspects abuse or exploitation

*Baseline will be developed in first reporting cycle*

**2.** # of staff who complete APS Training

Baseline.will.be.developed.in.first.reporting.cycle¡

**Story behind the baseline:** For many years, the issue of elder abuse, neglect, and exploitation was hidden in plain sight. Families and communities were often unaware of the severity of these problems, and many older adults suffered in silence. Older Vermonters, especially those living alone or in vulnerable situations, became easy targets for exploitation and neglect, with few resources dedicated to helping them. In the early days of this issue, the focus was largely reactive. Legal and social systems were not yet equipped to handle the complexities of elder care, and societal attitudes often dismissed the concerns of older adults as part of aging. Advocates and professionals began to recognize that preventing elder abuse, neglect, and exploitation was far more effective than reacting to it. This realization led to a stronger emphasis on education, awareness, and community involvement in protecting older adults. The public began to see that elder abuse was not an isolated issue, but a societal problem that required collective responsibility. Communities started coming together to ensure that older adults were treated with respect, dignity, and care. Training initiatives were established to help professionals recognize the warning signs of elder abuse, neglect, and exploitation. These programs focused on identifying subtle signs that might otherwise be overlooked, such as a sudden change in financial circumstances, unexplained injuries, or withdrawal from social activities. These efforts were designed not only to respond to incidents but to prevent them from occurring in the first place.

While the curve is still evolving, and challenges persist, the story behind the curve is one of awareness, education, and action. Through continued efforts to raise awareness and provide resources, communities are learning that the prevention of elder abuse, neglect, and exploitation requires a unified approach, where each of us plays a role in safeguarding our older generations.

**What works:** Continuous training of staff and community partners and their role in supporting older Vermonters. Effective strategies for addressing elder abuse, neglect, and exploitation focus on enhancing knowledge and responsiveness among staff members, leading to better protection for older Vermonters. The successful approach has centered around several key measures: increasing the number of substantiated referrals made to Adult Protective Services (APS) when abuse or exploitation is reported or suspected, monitoring client safety and ensuring that staff complete specialized APS training. Over time, shifting from reactive to proactive measures has proven essential. Early education and awareness initiatives have significantly contributed to a broader understanding of elder abuse as a serious societal issue, not just an isolated problem. Ensuring that staff are well-trained to recognize and respond to these reports is critical.

**Partners:** NVRH, NCH, Northern Counties Healthcare (encompasses medical offices, providers,and home health), senior centers and meal sites/MOW, housing sites, mental health providers/Eldercare Clinicians, DAIL, SASH, Senior Companions, transportation providers, primary care, nursing homes, and SHIP.

**Action plan:** What do we propose to actually do? What will we do to improve/strengthen/sustain performance? This can be a combination of things which could be done immediately and things which are part of a multi-year strategy.

> **Strategy 1 – Specific action to be taken**. To achieve the goal of improving staff knowledge on abuse and exploitation and enhancing their ability to make appropriate referrals, as well as identifying older Vermonters who don't feel safe in their home through annual reviews and at times during the year where such assessment is warranted. Support and Resources for Staff, provide opportunities for debriefing sessions and counseling for staff involved in intense cases. Comprehensive APS Training**, w**ork with Staff on training needs to keep current and informed of trends.
>
> **Strategy 2 - Specific action to be taken.** Expand awareness of the signs of and topic of elder abuse, exploitation and neglect through a community communications plan which encompasses a variety of media (social, front porch forum, website, newspaper, newsletters).

By implementing this action plan, NEKCOA can enhance its staff's ability to effectively recognize and respond to incidents of elder abuse, ensuring that vulnerable older adults receive the protection and care they deserve. This proactive approach not only addresses immediate needs but also contributes to the broader societal effort to prevent elder abuse.

## Section E: Agency Plan for Data Management and/or Development

Each member of the leadership team participates in monthly monitoring of data for their respective departments. This encompasses; Nutrition Director, Caregiving support Director, Care and Support Directors (this encompasses Helpline, Options Counseling, and Case Management), volunteer Coordinator, Communications and Development Director, IT Coordinator, MIS system coordinator and Fiscal Coordinator. The Executive Director meets individually with them to ensure monitoring and corrective action planning is developed if necessary.

This is our third year in Peer Place as our primary database, and it has been a unique learning curve after having been in the same previous database for over 20 years. The leadership team continues to monitor and use reporting functions to highlight areas in need of improvement to ensure that data is entered and tracking in the system properly. The first two years proved quite challenging in respect to establishing data entry protocols and reporting to monitor compliance. We have spent this third year further developing processes and quality assurance monitoring.

## Section F: Continuous Quality Improvement Plan

NEKCOA is committed to the necessary and ongoing work in training and monitoring the quality of data ensuring the goal of maintaining quality data within our systems.

We will set the standard established internally to ensure that staff are trained and held accountable to quality data integrity.

**Accountability roles:**

Executive Director is responsible for ensuring that the data reporting is being managed by department leads in accordance with policy. Routine meetings with leadership staff allow for oversight of maintenance of goals and priorities ensuring compliance. The ED reports to the board a series of monthly statistics that report on data from the database to monitor functions within the work reported.

IT Lead manages reporting and monitoring to ensure that accountable action is maintained throughout the system. Monthly reporting of nutrition, case management, and options counseling, and helpline ensure that timely response is achieved to any deficiencies found.

Department Leads: Leads will be responsible for monitoring staff work in the database thru regular note reviews and data entry reports so that monitoring is a routine part of the work of supervision and training. Nutrition programs are monitored monthly for accuracy of compliance with standards for meals and Registered dietician. Care and support department uses regular supervision and monthly review of notes to ensure compliance is achieved.

**Databases:**

**Peer Place** is the primary database used for all client contact from helpline, health insurance, volunteer services being received by clients, case management, options counseling, caregiving, and nutrition programs. The reporting and view builder monitoring of the data entry is carefully reviewed.

**Wellsky:**

**Sams is** utilized and monitored for those on specialized programs in an interactive effort with the HCBS system at DAIL. As clients served by OAA may have diverse needs they may be found recorded in both systems.

Better impact is the database used to track volunteers and their contributions to working with clients.

**Compliance External:**

DAIL provides external audits of Case Management services performed periodically. This audit evaluates data, compliance and ensures that standards are maintained according to state standards.

**Financial audit:**

An external third-party audit is contracted annually as required by state and federal grants. This audit is presented and overseen by the Board of Directors and Executive Director as supported by the Accountant and Fiscal Coordinator. Any findings are reviewed, and an action plan is developed to respond.

We applied to and are working with NCQA for Case Management standard accreditation in the winter of 2026 which has resulted in a significant review of policy and procedure to meet the high-level compliance standards set forth by this accreditation agency.

Additionally, new staff orientation provides a process of shadowing current employees, meeting all department heads, and an overall agency orientation. This orientation includes database and records training compliance.

Professional development training is offered through the monthly Care and Support Dept or full agency staff meetings.

## SECTION G. REQUEST FOR WAIVERS: NO WAIVERS REQUESTED AT THIS TIME.

## Section H: Public Hearing

March 3 - NEKProsper is the Accountable Health Care Organization and at the March leadership meeting we reviewed the needs assessments and plan for goals for the Area Plan. Input integrated into the plan. Present: Shawn Tester, CEO, NVRH, John Sayles, CEO Vt Foodbank, Jenna O'Farrell, ED for NEKCA, Kelsey Staveth, CEO NKHS, Amanda Cochran, ED Umbrella and Chris Towne, CEO Northern Counties Health Care.

April 7 - NEKProsper large group with is a group comprised of leadership team (see above) and community involvement. 22 people present. This is a monthly larger group of agencies, individuals interested in the work of NEK Prosper. Goals and action steps were discussed for review and feedback. This work aligns with the work of NEK Prosper to improve the overall health and wellbeing of residents of the NEK.

August 1 - We used our constant contact account to send the plan summary and plan to 1131 individuals. We hosted a live event on August 8 and had 4 people join to share their viewpoints of elder needs and review of the plan.

We posted the session access on Facebook and it was viewed by 388 people. Additionally, we offered one on one availability to review the Plan with the ED.

Additionally, 4 people reached out and left phone messages with comments about the Area Plan resulting from Facebook posting.

# ATTACHMENT A

## AREA AGENCY ASSURANCES AND REQUIRED ACTIVITIES
## Older Americans Act, As Amended in 2020

The Older Americans Act requires that to be approved by the State Agency, Area Agencies must make certain assurances. Below is a listing of the most current information provided by the Administration on Aging identifying new or amended assurances and information requirements which must be addressed in all area plans. Also included are the assurances and information requirements detailed in previous Administration on Aging guidance.

**Sec. 306, AREA PLANS**

(a) Each area agency on aging designated under section 305(a)(2)(A) shall, in order to be approved by the State agency, prepare and develop an area plan for a planning and service area for a two-, three-, or four-year period determined by the State agency, with such annual adjustments as may be necessary. Each such plan shall be based upon a uniform format for area plans within the State prepared in accordance with section 307(a)(1). Each such plan shall—

(1) provide, through a comprehensive and coordinated system, for supportive services, nutrition services, and, where appropriate, for the establishment, maintenance, modernization, or construction of multipurpose senior centers (including a plan to use the skills and services of older individuals in paid and unpaid work, including multigenerational and older individual to older individual work), within the planning and service area covered by the plan, including determining the extent of need for supportive services, nutrition services, and multipurpose senior centers in such area (taking into consideration, among other things, the number of older individuals with low incomes residing in such area, the number of older individuals who have greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals who have greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) residing in such area, the number of older individuals at risk for institutional placement residing in such area, and the number of older individuals who are Indians residing in such area, and the efforts of voluntary organizations in the community), evaluating the effectiveness of the use of resources in meeting such need, and entering into agreements with providers of supportive services, nutrition services, or multipurpose senior centers in such area, for the provision of such services or centers to meet such need;

(2) provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services—

(A) services associated with access to services (transportation, health services (including mental and behavioral health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible) and case management services);

(B) in-home services, including supportive services for families of older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;

and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded;

(3) (A) designate, where feasible, a focal point for comprehensive service delivery in each community, giving special consideration to designating multipurpose senior centers (including multipurpose senior centers operated by organizations referred to in paragraph (6)(C)) as such focal point; and

(B) specify, in grants, contracts, and agreements implementing the plan, the identity of each focal point so designated.

(4) (A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and

(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of sub-clause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

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

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(iii) with respect to the fiscal year preceding the fiscal year for which such plan is prepared —

(I) identify the number of low-income minority older individuals in the planning and service area;

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

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (i).

(B) provide assurances that the area agency on aging will use outreach efforts that will—

(i) identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

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

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

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement, specifically including survivors of the Holocaust; and

(ii) inform the older individuals referred to in sub-clauses (I) through (VII) of clause (i), and the caretakers of such individuals, of the availability of such assistance; and

(C) contain an assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities;

(6) provide that the area agency on aging will—

(A) take into account in connection with matters of general policy arising in the development and administration of the area plan, the views of recipients of services under such plan;

(B) serve as the advocate and focal point for older individuals within the community by (in cooperation with agencies, organizations, and individuals participating in activities under the plan) monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which will affect older individuals;

(C)(i) where possible, enter into arrangements with organizations providing day care services for children, assistance to older individuals caring for relatives who are children, and respite for families, so as to provide opportunities for older individuals to aid or assist on a voluntary basis in the delivery of such services to children, adults, and families;

(ii) if possible regarding the provision of services under this title, enter into arrangements and coordinate with organizations that have a proven record of providing services to older individuals, that—

(I) were officially designated as community action agencies or community action programs under section 210 of the Economic Opportunity Act of 1964 (42U.S.C. 2790) for fiscal year 1981, and did not lose the designation as a result of failure to comply with such Act; or

(II) came into existence during fiscal year 1982 as direct successors in interest to such community action agencies or community action programs;

and that meet the requirements under section 676B of the Community Services Block Grant Act; and

(iii) make use of trained volunteers in providing direct services delivered to older individuals and individuals with disabilities needing such services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National and Community Service), in community service settings;

(D) establish an advisory council consisting of older individuals (including minority individuals and older individuals residing in rural areas) who are participants or who are eligible to participate in programs assisted under this Act, family caregivers of such individuals, representatives of older individuals, service providers, representatives of the business community, local elected officials, providers of veterans' health care (if appropriate), and the general public, to advise continuously the area agency on aging on all matters relating to the development of the area plan, the administration of the plan and operations conducted under the plan;

(E) establish effective and efficient procedures for coordination of—

(i) entities conducting programs that receive assistance under this Act within the planning and service area served by the agency; and

(ii) entities conducting other Federal programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b), within the area;

(F) in coordination with the State agency and with the State agency responsible for mental and behavioral health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental and behavioral health services (including mental health screenings) provided with funds expended by the area agency on aging with mental and behavioral health services provided by community health centers and by other public agencies and nonprofit private organizations;

(G) if there is a significant population of older individuals who are Indians in the planning and service area of the area agency on aging, the area agency on aging shall conduct outreach activities to identify such individuals in such area and shall inform such individuals of the availability of assistance under this Act;

(H) in coordination with the State agency and with the State agency responsible for elder abuse prevention services, increase public awareness of elder abuse, neglect, and exploitation, and remove barriers to education, prevention, investigation, and treatment of elder abuse, neglect, and exploitation, as appropriate; and

(I) to the extent feasible, coordinate with the State agency to disseminate information about the State assistive technology entity and access to assistive technology options for serving older individuals;

(7) provide that the area agency on aging shall, consistent with this section, facilitate the areawide development and implementation of a comprehensive, coordinated system for providing long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals and their family caregivers, by—

(A) collaborating, coordinating activities, and consulting with other local public and private agencies and organizations responsible for administering programs, benefits, and services related to providing long-term care;

(B) conducting analyses and making recommendations with respect to strategies for modifying the local system of long-term care to better—

(i) respond to the needs and preferences of older individuals and family caregivers;

(ii) facilitate the provision, by service providers, of long-term care in home and community-based settings; and

(iii) target services to older individuals at risk for institutional placement, to permit such individuals to remain in home and community-based settings;

(C) implementing, through the agency or service providers, evidence-based programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce the risk of injury, disease, and disability among older individuals; and

(D) providing for the availability and distribution (through public education campaigns, Aging and Disability Resource Centers, the area agency on aging itself, and other appropriate means) of information relating to—

(i) the need to plan in advance for long-term care; and

(ii) the full range of available public and private long-term care (including integrated long-term care) programs, options, service providers, and resources;

(8) provide that case management services provided under this title through the area agency on aging will—

(A) not duplicate case management services provided through other Federal and State programs;

(B) be coordinated with services described in subparagraph (A); and

(C) be provided by a public agency or a nonprofit private agency that—

(i) gives each older individual seeking services under this title a list of agencies that provide similar services within the jurisdiction of the area agency on aging;

(ii) gives each individual described in clause (i) a statement specifying that the individual has a right to make an independent choice of service providers and documents receipt by such individual of such statement;

(iii) has case managers acting as agents for the individuals receiving the services and not as promoters for the agency providing such services; or

(iv) is located in a rural area and obtains a waiver of the requirements described in clauses (i) through (iii);

(9) (A) provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2019 in carrying out such a program under this title;

(B) funds made available to the area agency on aging pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712;

(10) provide a grievance procedure for older individuals who are dissatisfied with or denied services under this title;

(11) provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including—

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans;

(12) provide that the area agency on aging will establish procedures for coordination of services with entities conducting other Federal or federally assisted programs for older individuals at the local level, with particular emphasis on entities conducting programs described in section 203(b) within the planning and service area.

(13) provide assurances that the area agency on aging will—

(A) maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships;

(B) disclose to the Assistant Secretary and the State agency—

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship;

(C) demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such contract or such relationship;

(D) demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such contract or such relationship; and

(E) on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals;

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

(15) provide assurances that funds received under this title will be used—

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and

(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(16) provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care;

(17) include information detailing how the area agency on aging will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery;

(18) provide assurances that the area agency on aging will collect data to determine—

(A) the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019; and

(B) the effectiveness of the programs, policies, and services provided by such area agency on aging in assisting such individuals; and

(19) provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on those individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019.

(b)(1) An area agency on aging may include in the area plan an assessment of how prepared the area agency on aging and service providers in the planning and service area are for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(2) Such assessment may include—

(A) the projected change in the number of older individuals in the planning and service area;

(B) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(C) an analysis of how the programs, policies, and services provided by such area agency can be improved, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the planning and service area; and

(D) an analysis of how the change in the number of individuals age 85 and older in the planning and service area is expected to affect the need for supportive services.

(3) An area agency on aging, in cooperation with government officials, State agencies, tribal organizations, or local entities, may make recommendations to government officials in the planning and service area and the State, on actions determined by the area agency to build the capacity in the planning and service area to meet the needs of older individuals for—

(A) health and human services;
(B) land use;
(C) housing;
(D) transportation;
(E) public safety;
(F) workforce and economic development;
(G) recreation;
(H) education;
(I) civic engagement;
(J) emergency preparedness;
(K) protection from elder abuse, neglect, and exploitation;
(L) assistive technology devices and services; and
(M) any other service as determined by such agency.

(c) Each State, in approving area agency on aging plans under this section, shall waive the requirement described in paragraph (2) of subsection (a) for any category of services described in such paragraph if the area agency on aging demonstrates to the State agency that services being furnished for such category in the area are sufficient to meet the need for such services in such area and had conducted a timely public hearing upon request.

(d)(1) Subject to regulations prescribed by the Assistant Secretary, an area agency on aging designated under section 305(a)(2)(A) or, in areas of a State where no such agency has been designated, the State agency, may enter into agreement with agencies administering programs under the Rehabilitation Act of 1973, and titles XIX

and XX of the Social Security Act for the purpose of developing and implementing plans for meeting the common need for transportation services of individuals receiving benefits under such Acts and older individuals participating in programs authorized by this title.

(2) In accordance with an agreement entered into under paragraph (1), funds appropriated under this title may be used to purchase transportation services for older individuals and may be pooled with funds made available for the provision of transportation services under the Rehabilitation Act of 1973, and titles XIX and XX of the Social Security Act.

(e) An area agency on aging may not require any provider of legal assistance under this title to reveal any information that is protected by the attorney-client privilege.

(f)(1) If the head of a State agency finds that an area agency on aging has failed to comply with Federal or State laws, including the area plan requirements of this section, regulations, or policies, the State may withhold a portion of the funds to the area agency on aging available under this title.

(2) (A) The head of a State agency shall not make a final determination withholding funds under paragraph (1) without first affording the area agency on aging due process in accordance with procedures established by the State agency.

(B) At a minimum, such procedures shall include procedures for—

(i) providing notice of an action to withhold funds;

(ii) providing documentation of the need for such action; and

(iii) at the request of the area agency on aging, conducting a public hearing concerning the action.

(3) (A) If a State agency withholds the funds, the State agency may use the funds withheld to directly administer programs under this title in the planning and service area served by the area agency on aging for a period not to exceed 180 days, except as provided in subparagraph (B).

(B) If the State agency determines that the area agency on aging has not taken corrective action, or if the State agency does not approve the corrective action, during the 180-day period described in subparagraph (A), the State agency may extend the period for not more than 90 days.

(g) Nothing in this Act shall restrict an area agency on aging from providing services not provided or authorized by this Act, including through—

(1) contracts with health care payers;

(2) consumer private pay programs; or

(3) other arrangements with entities or individuals that increase the availability of home and community-based services and supports.

**Sec. 307, STATE PLANS**

(a) Except as provided in the succeeding sentence and section 309(a), each State, in order to be eligible for grants from its allotment under this title for any fiscal year, shall submit to the Assistant Secretary a State plan for a two, three, or four-year period determined by the State agency, with such annual revisions as are necessary, which meets such criteria as the Assistant Secretary may by regulation prescribe. If the Assistant Secretary determines, in the discretion of the Assistant Secretary, that a State failed in 2 successive years to comply with the requirements under this title, then the State shall submit to the Assistant Secretary a State plan for a 1-year period that meets such criteria, for subsequent years until the Assistant Secretary determines that the State is in compliance with such requirements. Each such plan shall comply with all of the following requirements:

(1) The plan shall—

(A) require each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) be based on such area plans.

(2) The plan shall provide that the State agency will—

(A) evaluate, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

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

(C) specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under section 306(c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2).

(3) The plan shall—

(A) include (and may not be approved unless the Assistant Secretary approves) the statement and demonstration required by paragraphs (2) and (4) of section 305(d) (concerning intrastate distribution of funds); and

(B) with respect to services for older individuals residing in rural areas—

(i) provide assurances that the State agency will spend for each fiscal year, not less than the amount expended for such services for fiscal year 2000…

(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services); and

(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas).

(5) The plan shall provide that the State agency will—

(A) afford an opportunity for a hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issue guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) afford an opportunity for a public hearing, upon request, by any area agency on aging, by any provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under section 316.

(6) The plan shall provide that the State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(7) (A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(B) The plan shall provide assurances that—

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(8) (A) The plan shall provide that no supportive services, nutrition services, or in-home services will be directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency—

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

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

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.

(B) Regarding case management services, if the State agency or area agency on aging is already providing case management services (as of the date of submission of the plan) under a State program, the plan may specify that such agency is allowed to continue to provide case management services.

(C) The plan may specify that an area agency on aging is allowed to directly provide information and assistance services and outreach.

(9) The plan shall provide assurances that—

(A) the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2019, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2019; and

(B) funds made available to the State agency pursuant to section 712 shall be used to supplement and not supplant other Federal, State, and local funds expended to support activities described in section 712.

(10) The plan shall provide assurances that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11) The plan shall provide that with respect to legal assistance —

(A) the plan contains assurances that area agencies on aging will (i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance; (ii) include in any such contract provisions to assure that any recipient of funds under division (i) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local

governing boards) as determined appropriate by the Assistant Secretary; and (iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis;

(B) the plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(C) the State agency will provide for the coordination of the furnishing of legal assistance to older individuals within the State, and provide advice and technical assistance in the provision of legal assistance to older individuals within the State and support the furnishing of training and technical assistance for legal assistance for older individuals;

(D) the plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals; and

(E) the plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals —

(A) the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for—

(i) public education to identify and prevent abuse of older individuals;

(ii) receipt of reports of abuse of older individuals;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(iv) referral of complaints to law enforcement or public protective service agencies where appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in this paragraph by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential unless all parties to the complaint consent in writing to the release of such information, except that such information may be released to a law enforcement or public protective service agency.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

(A) identify the number of low-income minority older individuals in the State, including the number of low-income minority older individuals with limited English proficiency; and

(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include—

(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who—

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

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

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

(21) The plan shall—

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made—

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

(27) (A) The plan shall include, at the election of the State, an assessment of how prepared the State is, under the State's statewide service delivery model, for any anticipated change in the number of older individuals during the 10-year period following the fiscal year for which the plan is submitted.

(B) Such assessment may include—

(i) the projected change in the number of older individuals in the State;

(ii) an analysis of how such change may affect such individuals, including individuals with low incomes, individuals with greatest economic need, minority older individuals, older individuals residing in rural areas, and older individuals with limited English proficiency;

(iii) an analysis of how the programs, policies, and services provided by the State can be improved, including coordinating with area agencies on aging, and how resource levels can be adjusted to meet the needs of the changing population of older individuals in the State; and

(iv) an analysis of how the change in the number of individuals age 85 and older in the State is expected to affect the need for supportive services.

(28) The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

(29) The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

(30) The plan shall contain an assurance that the State shall prepare and submit to the Assistant Secretary annual reports that describe—

(A) data collected to determine the services that are needed by older individuals whose needs were the focus of all centers funded under title IV in fiscal year 2019;

(B) data collected to determine the effectiveness of the programs, policies, and services provided by area agencies on aging in assisting such individuals; and

(C) outreach efforts and other activities carried out to satisfy the assurances described in paragraphs (18) and (19) of section 306(a).

## STANDARD STATE PROVISIONS FOR CONTRACTS AND GRANTS

**Revised December 7, 2023**

**1. Definitions:** For purposes of this Attachment, "Party" shall mean the Contractor, Grantee, or Subrecipient, with whom the State of Vermont is executing this Agreement and consistent with the form of the Agreement. "Agreement" shall mean the specific contract or grant to which this form is attached.

**2. Entire Agreement:** This Agreement, whether in the form of a contract, State-funded grant, or Federally-funded grant, represents the entire agreement between the parties on the subject matter. All prior agreements, representations, statements, negotiations, and understandings shall have no effect. Where an authorized individual is either required to click-through or otherwise accept, or made subject to, any electronic terms and conditions to use or access any product or service provided hereunder, such terms and conditions are not binding and shall have no force or effect. Further, any terms and conditions of Party's invoice, acknowledgment, confirmation, or similar document, shall not apply, and any such terms and conditions on any such document are objected to without need of further notice or objection.

**3. Governing Law, Jurisdiction and Venue; No Waiver of Jury Trial:** This Agreement will be governed by the laws of the State of Vermont without resort to conflict of laws principles. Any action or proceeding brought by either the State or the Party in connection with this Agreement shall be brought and enforced in the Superior Court of the State of Vermont, Civil Division, Washington Unit. The Party irrevocably submits to the jurisdiction of this court for any action or proceeding regarding this Agreement. The Party agrees that it must first exhaust any applicable administrative remedies with respect to any cause of action that it may have against the State regarding its performance under this Agreement. Party agrees that the State shall not be required to submit to binding arbitration or waive its right to a jury trial.

**4. Sovereign Immunity:** The State reserves all immunities, defenses, rights, or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution. No waiver of the State's immunities, defenses, rights, or actions shall be implied or otherwise deemed to exist by reason of the State's entry into this Agreement.

**5. No Employee Benefits For Party:** The Party understands that the State will not provide any individual retirement benefits, group life insurance, group health and dental insurance, vacation or sick leave, workers compensation or other benefits or services available to State employees, nor will the State withhold any state or Federal taxes except as required under applicable tax laws, which shall be determined in advance of execution of the Agreement. The Party understands that all tax returns required by the Internal Revenue Code and the State of Vermont, including but not limited to income, withholding, sales and use, and rooms and meals, must be filed by the Party, and information as to Agreement income will be provided by the State of Vermont to the Internal Revenue Service and the Vermont Department of Taxes.

**6. Independence:** The Party will act in an independent capacity and not as officers or employees of the State.

**7. Defense and Indemnity:**

1. The Party shall defend the State and its officers and employees against all third-party claims or suits arising in whole or in part from any act or omission of the Party or of any agent of the Party in connection with the performance of this Agreement. The State shall notify the Party in the event of any such claim or suit, and the Party shall immediately retain counsel and otherwise provide a complete defense against the entire claim or suit. The State retains the right to participate at its own expense in the defense of any claim. The State shall have the right to approve all proposed settlements of such claims or suits.

2. After a final judgment or settlement, the Party may request recoupment of specific defense costs and may file suit in Washington Superior Court requesting recoupment. The Party shall be entitled to recoup costs only upon a showing that such costs were entirely unrelated to the defense of any claim arising from an act or omission of the Party in connection with the performance of this Agreement.

3. The Party shall indemnify the State and its officers and employees if the State, its officers, or employees become legally obligated to pay any damages or losses arising from any act or omission of the Party or an agent of the Party in connection with the performance of this Agreement.

4. Notwithstanding any contrary language anywhere, in no event shall the terms of this Agreement or any document furnished by the Party in connection with its performance under this Agreement obligate the State to (1) defend or indemnify the Party or any third party, or (2) otherwise be liable for the expenses or reimbursement, including attorneys' fees, collection costs or other costs of the Party or any third party.

**8. Insurance:** During the term of this Agreement, Party, at its expense, shall maintain in full force and effect the insurance coverages set forth in the Vermont State Insurance Specification in effect at the time of incorporation of this Attachment C into this Agreement. The terms of the Vermont State Insurance Specification are hereby incorporated by reference into this Attachment C as if fully set forth herein. A copy of the Vermont State Insurance Specification is available at: https://aoa.vermont.gov/Risk-Claims-COI.

**9. Reliance by the State on Representations:** All payments by the State under this Agreement will be made in reliance upon the accuracy of all representations made by the Party in accordance with this Agreement, including but not limited to bills, invoices, progress reports, and other proofs of work.

**10. False Claims Act:** Any liability to the State under the Vermont False Claims Act (32 V.S.A. § 630 et seq.) shall not be limited notwithstanding any agreement of the State to otherwise limit Party's liability.

**11. Whistleblower Protections:** The Party shall not discriminate or retaliate against one of its employees or agents for disclosing information concerning a violation of law, fraud, waste, abuse of authority, or acts threatening health or safety, including but not limited to allegations concerning the False Claims Act. Further, the Party shall not require such employees or agents to forego monetary awards as a result of such disclosures, nor should they be required to report misconduct to the Party or its agents prior to reporting to any governmental entity and/or the public.

**12. Use and Protection of State Information:**

1. As between the State and Party, "State Data" includes all data received, obtained, or generated by the Party in connection with performance under this Agreement. Party acknowledges that certain State Data to which the Party may have access may contain information that is deemed confidential by the State, or which is otherwise confidential by law, rule, or practice, or otherwise exempt from disclosure under the State of Vermont Access to Public Records Act, 1 V.S.A. § 315 et seq. ("Confidential State Data").

2. With respect to State Data, Party shall:

    1. take reasonable precautions for its protection;
    2. not rent, sell, publish, share, or otherwise appropriate it; and

3. upon termination of this Agreement for any reason, Party shall dispose of or retain State Data if and to the extent required by this Agreement, law, or regulation, or otherwise requested in writing by the State.

3. With respect to Confidential State Data, Party shall:

1. strictly maintain its confidentiality;

2. not collect, access, use, or disclose it except as necessary to provide services to the State under this Agreement;

3. provide at a minimum the same care to avoid disclosure or unauthorized use as it provides to protect its own similar confidential and proprietary information;

4. implement and maintain administrative, technical, and physical safeguards and controls to protect against any anticipated threats or hazards or unauthorized access or use;

5. promptly notify the State of any request or demand by any court, governmental agency or other person asserting a demand or request for Confidential State Data so that the State may seek an appropriate protective order; and

6. upon termination of this Agreement for any reason, and except as necessary to comply with subsection B.iii above in this section, return or destroy all Confidential State Data remaining in its possession or control.

4. If Party is provided or accesses, creates, collects, processes, receives, stores, or transmits Confidential State Data in any electronic form or media, Party shall utilize:

1. industry-standard firewall protection;

2. multi-factor authentication controls;

3. encryption of electronic Confidential State Data while in transit and at rest;

4. measures to ensure that the State Data shall not be altered without the prior written consent of the State;

5. measures to protect against destruction, loss, or damage of State Data due to potential environmental hazards, such as fire and water damage;

6. training to implement the information security measures; and

7. monitoring of the security of any portions of the Party's systems that are used in the provision of the services against intrusion.

5. No Confidential State Data received, obtained, or generated by the Party in connection with performance under this Agreement shall be processed, transmitted, stored, or transferred by any means outside the United States, except with the express written permission of the State.

6. Party shall notify the State within twenty-four hours after becoming aware of any unauthorized destruction, loss, alteration, disclosure of, or access to, any State Data.

7. State of Vermont Cybersecurity Standard Update: Party confirms that all products and services provided to or for the use of the State under this Agreement shall be in compliance with State of Vermont Cybersecurity Standard Update in effect at the time of incorporation of this Attachment C

into this Agreement. The State of Vermont Cybersecurity Standard Update prohibits the use of certain branded products in State information systems or any vendor system, and a copy is available at: https://digitalservices.vermont.gov/cybersecurity/cybersecurity-standards-and-directives.

8. In addition to the requirements of this Section 12, Party shall comply with any additional requirements regarding the protection of data that may be included in this Agreement or required by law or regulation.

**13. Records Available for Audit:** The Party shall maintain all records pertaining to performance under this Agreement. "Records" means any written or recorded information, regardless of physical form or characteristics, which is produced or acquired by the Party in the performance of this Agreement. Records produced or acquired in a machine-readable electronic format shall be maintained in that format. The records described shall be made available at reasonable times during the period of this Agreement and for three years thereafter or for any period required by law for inspection by any authorized representatives of the State or Federal Government. If any litigation, claim, or audit is started before the expiration of the three-year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been resolved.

**14. Fair Employment Practices and Americans with Disabilities Act:** Party agrees to comply with the requirement of 21 V.S.A. Chapter 5, Subchapter 6, relating to fair employment practices, to the full extent applicable, and shall include this provision in all subcontracts for work performed in Vermont. Party shall also ensure, to the full extent required by the Americans with Disabilities Act of 1990, as amended, that qualified individuals with disabilities receive equitable access to the services, programs, and activities provided by the Party under this Agreement.

**15. Offset:** The State may offset any sums which the Party owes the State against any sums due the Party under this Agreement; provided, however, that any offset of amounts due the State of Vermont as taxes shall be in accordance with the procedures more specifically provided in 32 V.S.A. § 3113.

**16. Taxes Due to the State:** Party certifies under the pains and penalties of perjury that, as of the date this Agreement is signed, the Party is in good standing with respect to, or in full compliance with, a plan to pay any and all taxes due the State of Vermont.

**17. Taxation of Purchases:** All State purchases must be invoiced tax free. An exemption certificate will be furnished upon request with respect to otherwise taxable items.

**18. Child Support:** (Only applicable if the Party is a natural person, not a corporation or partnership.) Party states that, as of the date this Agreement is signed, Party is not under an obligation to pay child support or is in good standing with respect to or in full compliance with a plan to pay any and all child support payable under a support order. Party makes this statement with regard to support owed to any and all children residing in Vermont. In addition, if the Party is a resident of Vermont, Party makes this statement with regard to support owed to any and all children residing in any other state or territory of the United States.

**19. Sub-Agreements:** Party shall not assign, subcontract, or subgrant the performance of this Agreement or any portion thereof to any other Party without the prior written approval of the State. Party shall be responsible and liable to the State for all acts or omissions of subcontractors and any other person performing work under this Agreement pursuant to an agreement with Party or any subcontractor.

In the case this Agreement is a contract with a total cost in excess of $250,000, the Party shall provide to the State a list of all proposed subcontractors and subcontractors' subcontractors, together with the identity of those subcontractors' workers compensation insurance providers, and additional required or requested information, as

applicable, in accordance with Section 32 of The Vermont Recovery and Reinvestment Act of 2009 (Act No. 54), as amended by Section 17 of Act No. 142 (2010) and by Section 6 of Act No. 50 (2011).

Party shall include the following provisions of this Attachment C in all subcontracts for work performed solely for the State of Vermont and subcontracts for work performed in the State of Vermont: Section 10 ("False Claims Act"); Section 11 ("Whistleblower Protections"); Section 12 ("Confidentiality and Protection of State Information"); Section 14 ("Fair Employment Practices and Americans with Disabilities Act"); Section 16 ("Taxes Due the State"); Section 18 ("Child Support"); Section 20 ("No Gifts or Gratuities"); Section 22 ("Certification Regarding Debarment"); Section 30 ("State Facilities"); and Section 32.A ("Certification Regarding Use of State Funds").

**20. No Gifts or Gratuities:** Party shall not give title or possession of anything of substantial value (including property, currency, travel, and/or education programs) to any officer or employee of the State during the term of this Agreement.

**21. Regulation of Hydrofluorocarbons:** Party confirms that all products provided to or for the use of the State under this Agreement shall not contain hydrofluorocarbons, as prohibited under 10 V.S.A. § 586.

**22. Certification Regarding Debarment:** Party certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, neither Party nor Party's principals (officers, directors, owners, or partners) are presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in Federal programs, or programs supported in whole or in part by Federal funds. Party further certifies under pains and penalties of perjury that, as of the date that this Agreement is signed, Party is not presently debarred, suspended, nor named on the State's debarment list at: https://bgs.vermont.gov/purchasing-contracting/debarment.

**23. Conflict of Interest:** Party shall fully disclose, in writing, any conflicts of interest or potential conflicts of interest.

**24. Vermont Public Records Act:** Party acknowledges and agrees that this Agreement, any and all information obtained by the State from the Party in connection with this Agreement, and any obligations of the State to maintain the confidentiality of information are subject to the State of Vermont Access to Public Records Act, 1 V.S.A. § 315 *et seq.*

**25. Force Majeure:** Neither the State nor the Party shall be liable to the other for any failure or delay of performance of any obligations under this Agreement to the extent such failure or delay shall have been wholly or principally caused by acts or events beyond its reasonable control rendering performance illegal or impossible (excluding strikes or lockouts) ("Force Majeure"). Where Force Majeure is asserted, the nonperforming party must prove that it made all reasonable efforts to remove, eliminate or minimize such cause of delay or damages, diligently pursued performance of its obligations under this Agreement, substantially fulfilled all non-excused obligations, and timely notified the other party of the likelihood or actual occurrence of an event described in this paragraph.

**26. Marketing:** Party shall not use the State's logo or otherwise refer to the State in any publicity materials, information pamphlets, press releases, research reports, advertising, sales promotions, trade shows, or marketing materials or similar communications to third parties except with the prior written consent of the State.

**27. Termination:**

1. **Non-Appropriation:** If this Agreement extends into more than one fiscal year of the State (July 1 to June 30), and if appropriations are insufficient to support this Agreement, the State may cancel this Agreement at the end of the fiscal year, or otherwise upon the expiration of existing

appropriation authority. In the case that this Agreement is funded in whole or in part by Federal funds, and in the event Federal funds become unavailable or reduced, the State may suspend or cancel this Agreement immediately, and the State shall have no obligation to pay Party from State revenues.

2. **Termination for Cause:** Either party may terminate this Agreement if a party materially breaches its obligations under this Agreement, and such breach is not cured within thirty (30) days after delivery of the non-breaching party's notice or such longer time as the non-breaching party may specify in the notice.

3. **Termination Assistance:** Upon nearing the end of the final term or termination of this Agreement, without respect to cause, the Party shall take all reasonable and prudent measures to facilitate any transition required by the State. All State property, tangible and intangible, shall be returned to the State upon demand at no additional cost to the State in a format acceptable to the State.

**28. Continuity of Performance:** In the event of a dispute between the Party and the State, each party will continue to perform its obligations under this Agreement during the resolution of the dispute until this Agreement is terminated in accordance with its terms.

**29. No Implied Waiver of Remedies:** Either party's delay or failure to exercise any right, power, or remedy under this Agreement shall not impair any such right, power, or remedy, or be construed as a waiver of any such right, power, or remedy. All waivers must be in writing.

**30. State Facilities:** If the State makes space available to the Party in any State facility during the term of this Agreement for purposes of the Party's performance under this Agreement, the Party shall only use the space in accordance with all policies and procedures governing access to, and use of, State facilities, which shall be made available upon request. State facilities will be made available to Party on an "AS IS, WHERE IS" basis, with no warranties whatsoever.

**31. Requirements Pertaining Only to Federal Grants and Subrecipient Agreements:** If this Agreement is a grant that is funded in whole or in part by Federal funds:

1. **Requirement to Have a Single Audit:** The Subrecipient will complete the Subrecipient Annual Report annually within 45 days after its fiscal year end, informing the State of Vermont whether or not a Single Audit is required for the prior fiscal year. If a Single Audit is required, the Subrecipient will submit a copy of the audit report to the Federal Audit Clearinghouse within nine months. If a single audit is not required, only the Subrecipient Annual Report is required. A Single Audit is required if the subrecipient expends $750,000 or more in Federal assistance during its fiscal year and must be conducted in accordance with 2 CFR Chapter I, Chapter II, Part 200, Subpart F. The Subrecipient Annual Report is required to be submitted within 45 days, whether or not a Single Audit is required.

2. **Internal Controls:** In accordance with 2 CFR Part II, §200.303, the Party must establish and maintain effective internal control over the Federal award to provide reasonable assurance that the Party is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States and the "Internal Control Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission.

3. **Mandatory Disclosures:** In accordance with 2 CFR Part II, §200.113, Party must disclose, in a timely manner, in writing to the State, all violations of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Failure to make required disclosures may result in the imposition of sanctions which may include disallowance of costs incurred, withholding of payments, termination of the Agreement, suspension/debarment, etc.

**32. Requirements Pertaining Only to State-Funded Grants:**

1. **Certification Regarding Use of State Funds:** If Party is an employer and this Agreement is a State-funded grant in excess of $1,000, Party certifies that none of these State funds will be used to interfere with or restrain the exercise of Party's employee's rights with respect to unionization.

2. **Good Standing Certification (Act 154 of 2016):** If this Agreement is a State-funded grant, Party hereby represents: (i) that it has signed and provided to the State the form prescribed by the Secretary of Administration for purposes of certifying that it is in good standing (as provided in Section 13(a)(2) of Act 154) with the Agency of Natural Resources and the Agency of Agriculture, Food and Markets, or otherwise explaining the circumstances surrounding the inability to so certify; and (ii) that it will comply with the requirements stated therein.

(End of Standard Provisions)

**BUSINESS ASSOCIATE agreement**

**SOV Contractor/Grantee/business associate: NEKCOA**

**SOV CONTRACT No. 2026-2029 Area Plan**

**CONTRACT Effective DATE: 10/01/2025**

This Business Associate Agreement ("Agreement") is entered into by and between the State of Vermont Agency of Human Services, operating by and through its **Department of Disabilities, Aging, and Independent Living** ("Covered Entity") and Party identified in this Agreement as Contractor or Grantee above **("**Business Associate"). This Agreement supplements and is made a part of the contract or grant (Contract or Grant) to which it is attached.

Covered Entity and Business Associate enter into this Agreement to comply with the standards promulgated under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Standards for the Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164 ("Privacy Rule"), and the Security Standards, at 45 CFR Parts 160 and 164 ("Security Rule"), as amended by Subtitle D of the Health Information Technology for Economic and Clinical Health Act (HITECH), and any associated federal rules and regulations.

**The parties agree as follows:**

**1. Definitions**. All capitalized terms used but not otherwise defined in this Agreement have the meanings set forth in 45 CFR Parts 160 and 164 as amended by HITECH and associated federal rules and regulations. Terms defined in this Agreement are italicized. Unless otherwise specified, when used in this Agreement, defined terms used in the singular shall be understood if appropriate in their context to include the plural when applicable.

"*Agent*" means an Individual acting within the scope of the agency of the *Business Associate*, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c) and includes Workforce members and *Subcontractors*.

"*Breach*" means the acquisition, Access, Use or Disclosure of *Protected Health Information* (*PHI*) which compromises the Security or privacy of the *PHI*, except as excluded in the definition of *Breach* in 45 CFR § 164.402.

"*Business Associate*" shall have the meaning given for "Business Associate" in 45 CFR § 160.103 and means Contractor or Grantee and includes its Workforce, *Agents* and *Subcontractors*.

"*Electronic PHI*" shall mean *PHI* created, received, maintained or transmitted electronically in accordance with 45 CFR § 160.103.

"*Individual*" includes a Person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

"*Protected Health Information*" ("*PHI*") shall have the meaning given in 45 CFR § 160.103, limited to the *PHI* created or received by *Business Associate* from or on behalf of Covered Entity.

"*Required by Law*" means a mandate contained in law that compels an entity to make a use or disclosure of *PHI* and that is enforceable in a court of law and shall have the meaning given in 45 CFR § 164.103.

"*Report*" means submissions required by this Agreement as provided in section 2.3.

"*Security Incident*" means the attempted or successful unauthorized Access, Use, Disclosure, modification, or destruction of Information or interference with system operations in an Information System relating to *PHI* in accordance with 45 CFR § 164.304.

"*Services*" includes all work performed by the *Business Associate* for or on behalf of Covered Entity that requires the Use and/or Disclosure of *PHI* to perform a *Business Associate* function described in 45 CFR § 160.103.

"*Subcontractor*" means a Person to whom *Business Associate* delegates a function, activity, or service, other than in the capacity of a member of the workforce of such *Business Associate*.

"*Successful Security Incident*" shall mean a *Security Incident* that results in the unauthorized Access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

"*Unsuccessful Security Incident*" shall mean a *Security Incident* such as routine occurrences that do not result in unauthorized Access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System, such as: (i) unsuccessful attempts to penetrate computer networks or services maintained by *Business Associate*; and (ii) immaterial incidents such as pings and other broadcast attacks on *Business Associate's* firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above with respect to *Business Associate's* Information System.

"*Targeted Unsuccessful Security Incident*" means an *Unsuccessful Security Incident* that appears to be an attempt to obtain unauthorized Access, Use, Disclosure, modification or destruction of the Covered Entity's *Electronic PHI*.

**2. Contact Information for Privacy and Security Officers and Reports.**

2.1 *Business Associate* shall provide, within ten (10) days of the execution of this Agreement, written notice to the Contract or Grant manager the names and contact information of both the HIPAA Privacy Officer and HIPAA Security Officer of the *Business Associate*. This information must be updated by *Business Associate* any time these contacts change.

2.2 Covered Entity's HIPAA Privacy Officer and HIPAA Security Officer contact information is posted at:

http://humanservices.vermont.gov/policy-legislation/hipaa/hipaa-info-beneficiaries/ahs-hipaa-contacts/

2.3 *Business Associate* shall submit all *Reports* required by this Agreement to the following email address: AHS.PrivacyAndSecurity@vermont.gov

**3. Permitted and Required Uses/Disclosures of PHI**.

3.1 Subject to the terms in this Agreement, *Business Associate* may Use or Disclose *PHI* to perform *Services*, as specified in the Contract or Grant. Such Uses and Disclosures are limited to the minimum necessary to provide the *Services*. *Business Associate* shall not Use or Disclose *PHI* in any manner that would constitute a violation of the Privacy Rule if Used or Disclosed by Covered Entity in that manner. *Business Associate* may not Use or Disclose *PHI* other than as permitted or required by this Agreement or as *Required by Law* and only in compliance with applicable laws and regulations.

3.2 *Business Associate* may make *PHI* available to its Workforce, *Agent* and *Subcontractor* who need Access to perform *Services* as permitted by this Agreement, provided that *Business Associate* makes them aware of the Use and Disclosure restrictions in this Agreement and binds them to comply with such restrictions.

3.3 *Business Associate* shall be directly liable under HIPAA for impermissible Uses and Disclosures of *PHI*.

**4. Business Activities**. *Business Associate* may Use *PHI* if necessary for *Business Associate's* proper management and administration or to carry out its legal responsibilities. *Business Associate* may Disclose *PHI* for *Business Associate's* proper management and administration or to carry out its legal responsibilities if a Disclosure is *Required by Law* or if *Business Associate* obtains reasonable written assurances via a written agreement from the Person to whom the information is to be Disclosed

that such *PHI* shall remain confidential and be Used or further Disclosed only as *Required by Law* or for the purpose for which it was Disclosed to the Person, and the Agreement requires the Person to notify *Business Associate*, within five (5) business days, in writing of any *Breach* of Unsecured *PHI* of which it is aware. Such Uses and Disclosures of *PHI* must be of the minimum amount necessary to accomplish such purposes.

**5. Electronic PHI Security Rule Obligations**.

5.1 With respect to *Electronic PHI*, *Business Associate* shall:

a) Implement and use Administrative, Physical, and Technical Safeguards in compliance with 45 CFR sections 164.308, 164.310, and 164.312;

b) Identify in writing upon request from Covered Entity all the safeguards that it uses to protect such Electronic PHI;

c) Prior to any Use or Disclosure of *Electronic PHI* by an *Agent* or *Subcontractor*, ensure that any *Agent* or *Subcontractor* to whom it provides *Electronic PHI* agrees in writing to implement and use Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of Electronic PHI. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the Use or Disclosure of *Electronic PHI*, and be provided to Covered Entity upon request.

d) Report in writing to Covered Entity any *Successful Security Incident* or *Targeted Security Incident* as soon as it becomes aware of such incident and in no event later than five (5) business days after such awareness. Such report shall be timely made notwithstanding the fact that little information may be known at the time of the report and need only include such information then available.

e) Following such report, provide Covered Entity with the information necessary for Covered Entity to investigate any such incident; and

f) Continue to provide to Covered Entity information concerning the incident as it becomes available to it.

5.2 Reporting *Unsuccessful Security Incidents. Business Associate* shall provide Covered Entity upon written request a *Report* that: (a) identifies the categories of Unsuccessful Security Incidents; (b) indicates whether *Business Associate* believes its current defensive security measures are adequate to address all Unsuccessful Security Incidents, given the scope and nature of such attempts; and (c) if the security measures are not adequate, the measures *Business Associate* will implement to address the security inadequacies.

5.3 *Business Associate* shall comply with any reasonable policies and procedures Covered Entity implements to obtain compliance under the Security Rule.

**6. <u>Reporting and Documenting Breaches</u>**.

6.1 *Business Associate* shall *Report* to Covered Entity any *Breach* of Unsecured *PHI* as soon as it, or any Person to whom *PHI* is disclosed under this Agreement, becomes aware of any such *Breach*, and in no event later than five (5) business days after such awareness, except when a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security. Such *Report* shall be timely made notwithstanding the fact that little information may be known at the time of the *Report* and need only include such information then available.

6.2 Following the *Report* described in 6.1, *Business Associate* shall conduct a risk assessment and provide it to Covered Entity with a summary of the event. *Business Associate* shall provide Covered Entity with the names of any *Individual* whose Unsecured *PHI* has been, or is reasonably believed to have been, the subject of the *Breach* and any other available information that is required to be given to the affected *Individual*, as set forth in 45 CFR § 164.404(c). Upon request by Covered Entity, *Business Associate* shall provide information necessary for Covered Entity to investigate the impermissible Use or Disclosure. *Business Associate* shall continue to provide to Covered Entity information concerning the *Breach* as it becomes available.

6.3 When *Business Associate* determines that an impermissible acquisition, Access, Use or Disclosure of *PHI* for which it is responsible is not a *Breach*, and therefore does not necessitate notice to the impacted *Individual*, it shall document its assessment of risk, conducted as set forth in 45 CFR § 402(2). *Business Associate* shall make its risk assessment available to Covered Entity upon request. It shall include 1) the name of the person making the assessment, 2) a brief summary of the facts, and 3) a brief statement of the reasons supporting the determination of low probability that the *PHI* had been compromised.

**7.** **Mitigation and Corrective Action.** *Business Associate* shall mitigate, to the extent practicable, any harmful effect that is known to it of an impermissible Use or Disclosure of *PHI*, even if the impermissible Use or Disclosure does not constitute a *Breach*. *Business Associate* shall draft and carry out a plan of corrective action to address any incident of impermissible Use or Disclosure of *PHI*. *Business Associate* shall make its mitigation and corrective action plans available to Covered Entity upon request.

**8.** **Providing Notice of Breaches**.

8.1 If Covered Entity determines that a *Breach* of *PHI* for which *Business Associate* was responsible, and if requested by Covered Entity, *Business Associate* shall provide notice to the *Individual* whose *PHI* has been the subject of the *Breach*. When so requested, *Business Associate* shall consult with Covered Entity about the timeliness, content and method of notice, and shall receive Covered Entity's approval concerning these elements. *Business Associate* shall be responsible for the cost of notice and related remedies.

8.2 The notice to affected *Individuals* shall be provided as soon as reasonably possible and in no case later than 60 calendar days after *Business Associate* reported the *Breach* to Covered Entity.

8.3 The notice to affected *Individuals* shall be written in plain language and shall include, to the extent possible, 1) a brief description of what happened, 2) a description of the types of Unsecured *PHI* that were involved in the *Breach*, 3) any steps *Individuals* can take to protect themselves from potential harm resulting from the *Breach*, 4) a brief description of what the *Business Associate* is doing to investigate the *Breach* to mitigate harm to *Individuals* and to protect against further *Breaches*, and 5) contact procedures for *Individuals* to ask questions or obtain additional information, as set forth in 45 CFR § 164.404(c).

8.4 *Business Associate* shall notify *Individuals* of *Breaches* as specified in 45 CFR § 164.404(d) (methods of *Individual* notice). In addition, when a *Breach* involves more than 500 residents of Vermont, *Business Associate* shall, if requested by Covered Entity, notify prominent media outlets serving Vermont, following the requirements set forth in 45 CFR § 164.406.

**9.** **Agreements with Subcontractors**. *Business Associate* shall enter into a Business Associate Agreement with any *Subcontractor* to whom it provides *PHI* to require compliance with HIPAA and to ensure *Business Associate* and *Subcontractor* comply with the terms and conditions of this Agreement. *Business Associate* must enter into such written agreement before any Use by or Disclosure of *PHI* to such *Subcontractor*. The written agreement must identify Covered Entity as a direct and intended third party beneficiary with the right to enforce any breach of the agreement concerning the Use or Disclosure of *PHI*. *Business Associate* shall provide a copy of the written agreement it enters into with a *Subcontractor* to Covered Entity upon request. *Business Associate* may not make any Disclosure of *PHI* to any *Subcontractor* without prior written consent of Covered Entity.

**10.** **Access to PHI**. *Business Associate* shall provide access to *PHI* in a Designated Record Set to Covered Entity or as directed by Covered Entity to an *Individual* to meet the requirements under 45 CFR § 164.524. *Business Associate* shall provide such access in the time and manner reasonably

designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any request for Access to *PHI* that *Business Associate* directly receives from an *Individual*.

**11. Amendment of PHI**. *Business Associate* shall make any amendments to *PHI* in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526, whether at the request of Covered Entity or an *Individual*. *Business Associate* shall make such amendments in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any request for amendment to *PHI* that *Business Associate* directly receives from an *Individual*.

**12. Accounting of Disclosures**. *Business Associate* shall document Disclosures of *PHI* and all information related to such Disclosures as would be required for Covered Entity to respond to a request by an *Individual* for an accounting of disclosures of *PHI* in accordance with 45 CFR § 164.528. *Business Associate* shall provide such information to Covered Entity or as directed by Covered Entity to an *Individual*, to permit Covered Entity to respond to an accounting request. *Business Associate* shall provide such information in the time and manner reasonably designated by Covered Entity. Within five (5) business days, *Business Associate* shall forward to Covered Entity for handling any accounting request that *Business Associate* directly receives from an *Individual*.

**13. Books and Records**. Subject to the attorney-client and other applicable legal privileges, *Business Associate* shall make its internal practices, books, and records (including policies and procedures and *PHI*) relating to the Use and Disclosure of *PHI* available to the Secretary of Health and Human Services (HHS) in the time and manner designated by the Secretary. *Business Associate* shall make the same information available to Covered Entity, upon Covered Entity's request, in the time and manner reasonably designated by Covered Entity so that Covered Entity may determine whether *Business Associate* is in compliance with this Agreement.

**14. Termination.**

14.1 This Agreement commences on the Effective Date and shall remain in effect until terminated by Covered Entity or until all the *PHI* is destroyed or returned to Covered Entity subject to Section 18.8.

14.2 If *Business Associate* fails to comply with any material term of this Agreement, Covered Entity may provide an opportunity for *Business Associate* to cure. If *Business Associate* does not cure within the time specified by Covered Entity or if Covered Entity believes that cure is not reasonably possible, Covered Entity may immediately terminate the Contract or Grant without incurring liability or penalty for such termination. If neither termination nor cure are feasible, Covered Entity shall report the breach to the Secretary of HHS. Covered Entity has the right to seek to cure such failure by *Business Associate*. Regardless of whether Covered Entity cures, it retains any right or remedy available at law, in equity, or under the Contract or Grant and *Business Associate* retains its responsibility for such failure.

**15. Return/Destruction of PHI**.

15.1 *Business Associate* in connection with the expiration or termination of the Contract or Grant shall return or destroy, at the discretion of the Covered Entity, *PHI* that *Business Associate* still maintains in any form or medium (including electronic) within thirty (30) days after such expiration or termination. *Business Associate* shall not retain any copies of *PHI*. *Business Associate* shall certify in writing and report to Covered Entity (1) when all *PHI* has been returned or destroyed and (2) that *Business Associate* does not continue to maintain any *PHI*. *Business Associate* is to provide this certification during this thirty (30) day period.

15.2 *Business Associate* shall report to Covered Entity any conditions that *Business Associate* believes make the return or destruction of *PHI* infeasible. *Business Associate* shall extend the protections of this Agreement to such *PHI* and limit further Uses and Disclosures to those purposes that make the return or destruction infeasible for so long as *Business Associate* maintains such *PHI*.

**16. Penalties**. - *Business Associate* understands that: (a) there may be civil or criminal penalties for misuse or misappropriation of *PHI* and (b) violations of this Agreement may result in notification by Covered Entity to law enforcement officials and regulatory, accreditation, and licensure organizations.

**17. Training -** *Business Associate* understands its obligation to comply with the law and shall provide appropriate training and education to ensure compliance with this Agreement. If requested by Covered Entity, *Business Associate* shall participate in Covered Entity's training regarding the Use, Confidentiality, and Security of *PHI*; however, participation in such training shall not supplant nor relieve *Business Associate* of its obligations under this Agreement to independently assure compliance with the law and this Agreement.

**18. Miscellaneous.**

18.1 In the event of any conflict or inconsistency between the terms of this Agreement and the terms of the Contract or Grant, the terms of this Agreement shall govern with respect to its subject matter. Otherwise, the terms of the Contract or Grant continue in effect.

18.2 Each party shall cooperate with the other party to amend this Agreement from time to time as is necessary for such party to comply with the Privacy Rule, the Security Rule, or any other standards promulgated under HIPAA. This Agreement may not be amended, except by a writing signed by all parties hereto.

18.3 Any ambiguity in this Agreement shall be resolved to permit the parties to comply with the Privacy Rule, Security Rule, or any other standards promulgated under HIPAA.

18.4 In addition to applicable Vermont law, the parties shall rely on applicable federal law (e.g., HIPAA, the Privacy Rule, Security Rule, and HITECH) in construing the meaning and effect of this Agreement.

18.5 *Business Associate* shall not have or claim any ownership of *PHI*.

18.6 *Business Associate* shall abide by the terms and conditions of this Agreement with respect to all *PHI* even if some of that information relates to specific services for which *Business Associate* may not be a "*Business Associate*" of Covered Entity under the Privacy Rule.

18.7 *Business Associate* is prohibited from directly or indirectly receiving any remuneration in exchange for an *Individual's PHI*. *Business Associate* will refrain from marketing activities that would violate HIPAA, including specifically Section 13406 of the HITECH Act. Reports or data containing *PHI* may not be sold without Covered Entity's or the affected Individual's written consent.

18.8 The provisions of this Agreement that by their terms encompass continuing rights or responsibilities shall survive the expiration or termination of this Agreement. For example: (a) the provisions of this Agreement shall continue to apply if Covered Entity determines that it would be infeasible for *Business Associate* to return or destroy *PHI* as provided in Section 14.2 and (b) the obligation of *Business Associate* to provide an accounting of disclosures as set forth in Section 12 survives the expiration or termination of this Agreement with respect to accounting requests, if any, made after such expiration or termination.

## AGENCY OF HUMAN SERVICES' CUSTOMARY CONTRACT/GRANT PROVISIONS

1. **Definitions:** For purposes of this Attachment F, the term "Agreement" shall mean the form of the contract or grant, with all of its parts, into which this Attachment F is incorporated. The meaning of the term "Party" when used in this Attachment F shall mean any named party to this Agreement *other than* the State of Vermont, the Agency of Human Services (AHS) and any of the departments, boards, offices and business units named in this Agreement. As such, the term "Party" shall mean, when used in this Attachment F, the Contractor or Grantee with whom the State of Vermont is executing this Agreement. If Party, when permitted to do so under this Agreement, seeks by way of any subcontract, sub-grant or other form of provider agreement to employ any other person or entity to perform any of the obligations of Party under this Agreement, Party shall be obligated to ensure that all terms of this Attachment F are followed. As such, the term "Party" as used herein shall also be construed as applicable to, and describing the obligations of, any subcontractor, sub-recipient or sub-grantee of this Agreement. Any such use or construction of the term "Party" shall not, however, give any subcontractor, sub-recipient or sub-grantee any substantive right in this Agreement without an express written agreement to that effect by the State of Vermont.

2. **Agency of Human Services**: The Agency of Human Services is responsible for overseeing all contracts and grants entered by any of its departments, boards, offices and business units, however denominated. The Agency of Human Services, through the business office of the Office of the Secretary, and through its Field Services Directors, will share with any named AHS-associated party to this Agreement oversight, monitoring and enforcement responsibilities. Party agrees to cooperate with both the named AHS-associated party to this contract and with the Agency of Human Services itself with respect to the resolution of any issues relating to the performance and interpretation of this Agreement, payment matters and legal compliance.

3. **Medicaid Program Parties** (*applicable to any Party providing services and supports paid for under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver*):

   ***Inspection and Retention of Records***: In addition to any other requirement under this Agreement or at law, Party must fulfill all state and federal legal requirements, and will comply with all requests appropriate to enable the Agency of Human Services, the U.S. Department of Health and Human Services (along with its Inspector General and the Centers for Medicare and Medicaid Services), the Comptroller General, the Government Accounting Office, or any of their designees: (i) to evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed under this Agreement; and (ii) to inspect and audit any records, financial data, contracts, computer or other electronic systems of Party relating to the performance of services under Vermont's Medicaid program and Vermont's Global Commitment to Health Waiver. Party will retain for ten years all documents required to be retained pursuant to 42 CFR 438.3(u).

   ***Subcontracting for Medicaid Services***: Notwithstanding any permitted subcontracting of services to be performed under this Agreement, Party shall remain responsible for ensuring that this Agreement is fully performed according to its terms, that subcontractor remains in compliance with the terms

hereof, and that subcontractor complies with all state and federal laws and regulations relating to the Medicaid program in Vermont. Subcontracts, and any service provider agreements entered into by Party in connection with the performance of this Agreement, must clearly specify in writing the responsibilities of the subcontractor or other service provider and Party must retain the authority to revoke its subcontract or service provider agreement or to impose other sanctions if the performance of the subcontractor or service provider is inadequate or if its performance deviates from any requirement of this Agreement. Party shall make available on request all contracts, subcontracts and service provider agreements between the Party, subcontractors and other service providers to the Agency of Human Services and any of its departments as well as to the Center for Medicare and Medicaid Services.

***Medicaid Notification of Termination Requirements***: Party shall follow the Department of Vermont Health Access Managed-Care-Organization enrollee-notification requirements, to include the requirement that Party provide timely notice of any termination of its practice.

***Encounter Data***: Party shall provide encounter data to the Agency of Human Services and/or its departments and ensure further that the data and services provided can be linked to and supported by enrollee eligibility files maintained by the State.

***Federal Medicaid System Security Requirements Compliance***: Party shall provide a security plan, risk assessment, and security controls review document within three months of the start date of this Agreement (and update it annually thereafter) in order to support audit compliance with 45 CFR 95.621 subpart F, *ADP System Security Requirements and Review Process*.

4. **Workplace Violence Prevention and Crisis Response** (*applicable to any Party and any subcontractors and sub-grantees whose employees or other service providers deliver social or mental health services directly to individual recipients of such services*):

Party shall establish a written workplace violence prevention and crisis response policy meeting the requirements of Act 109 (2016), 33 VSA §8201(b), for the benefit of employees delivering direct social or mental health services. Party shall, in preparing its policy, consult with the guidelines promulgated by the U.S. Occupational Safety and Health Administration for *Preventing Workplace Violence for Healthcare and Social Services Workers*, as those guidelines may from time to time be amended.

Party, through its violence protection and crisis response committee, shall evaluate the efficacy of its policy, and update the policy as appropriate, at least annually. The policy and any written evaluations thereof shall be provided to employees delivering direct social or mental health services.

Party will ensure that any subcontractor and sub-grantee who hires employees (or contracts with service providers) who deliver social or mental health services directly to individual recipients of such services complies with all requirements of this Section.

5. **Non-Discrimination**:

Party shall not discriminate, and will prohibit its employees, agents, subcontractors, sub-grantees and other service providers from discrimination, on the basis of age under the Age Discrimination Act of 1975, on the basis of handicap under section 504 of the Rehabilitation Act of 1973, on the basis of sex under Title IX of the Education Amendments of 1972, and on the basis of race, color or national origin under Title VI of the Civil Rights Act of 1964. Party shall not refuse, withhold from or deny to any person the benefit of services, facilities, goods, privileges, advantages, or benefits of public accommodation on the basis of disability, race, creed, color, national origin, marital status, sex, sexual orientation or gender identity as provided by Title 9 V.S.A. Chapter 139.

No person shall on the grounds of religion or on the grounds of sex (including, on the grounds that a woman is pregnant), be excluded from participation in, be denied the benefits of, or be subjected to discrimination, to include sexual harassment, under any program or activity supported by State of Vermont and/or federal funds.

Party further shall comply with the non-discrimination requirements of Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, et seq., and with the federal guidelines promulgated pursuant to Executive Order 13166 of 2000, requiring that contractors and subcontractors receiving federal funds assure that persons with limited English proficiency can meaningfully access services. To the extent Party provides assistance to individuals with limited English proficiency through the use of oral or written translation or interpretive services, such individuals cannot be required to pay for such services.

6. **Employees and Independent Contractors**:

Party agrees that it shall comply with the laws of the State of Vermont with respect to the appropriate classification of its workers and service providers as "employees" and "independent contractors" for all purposes, to include for purposes related to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party agrees to ensure that all of its subcontractors or sub-grantees also remain in legal compliance as to the appropriate classification of "workers" and "independent contractors" relating to unemployment compensation insurance and workers compensation coverage, and proper payment and reporting of wages. Party will on request provide to the Agency of Human Services information pertaining to the classification of its employees to include the basis for the classification. Failure to comply with these obligations may result in termination of this Agreement.

7. **Data Protection and Privacy:**

***Protected Health Information***: Party shall maintain the privacy and security of all individually identifiable health information acquired by or provided to it as a part of the performance of this Agreement. Party shall follow federal and state law relating to privacy and security of individually identifiable health information as applicable, including the Health Insurance Portability and Accountability Act (HIPAA) and its federal regulations.

***Substance Abuse Treatment Information***: Substance abuse treatment information shall be maintained in compliance with 42 C.F.R. Part 2 if the Party or subcontractor(s) are Part 2 covered programs, or if substance abuse treatment information is received from a Part 2 covered program by the Party or subcontractor(s).

***Protection of Personal Information***: Party agrees to comply with all applicable state and federal statutes to assure protection and security of personal information, or of any personally identifiable information (PII), including the Security Breach Notice Act, 9 V.S.A. § 2435, the Social Security Number Protection Act, 9 V.S.A. § 2440, the Document Safe Destruction Act, 9 V.S.A. § 2445 and 45 CFR 155.260. As used here, PII shall include any information, in any medium, including electronic, which can be used to distinguish or trace an individual's identity, such as his/her name, social security number, biometric records, etc., either alone or when combined with any other personal or identifiable information that is linked or linkable to a specific person, such as date and place or birth, mother's maiden name, etc.

***Other Confidential Consumer Information***: Party agrees to comply with the requirements of AHS Rule No. 08-048 concerning access to and uses of personal information relating to any beneficiary or recipient of goods, services or other forms of support. Party further agrees to comply with any applicable Vermont State Statute and other regulations respecting the right to individual privacy. Party shall ensure that all of its employees, subcontractors and other service providers performing services under this agreement understand and preserve the sensitive, confidential and non-public nature of information to which they may have access.

***Data Breaches***: Party shall report to AHS, though its Chief Information Officer (CIO), any impermissible use or disclosure that compromises the security, confidentiality or privacy of any form of protected personal information identified above within 24 hours of the discovery of the breach. Party shall in addition comply with any other data breach notification requirements required under federal or state law.

8. **Abuse and Neglect of Children and Vulnerable Adults:**

***Abuse Registry***. Party agrees not to employ any individual, to use any volunteer or other service provider, or to otherwise provide reimbursement to any individual who in the performance of services connected with this agreement provides care, custody, treatment, transportation, or supervision to children or to vulnerable adults if there has been a substantiation of abuse or neglect or exploitation involving that individual. Party is responsible for confirming as to each individual having such contact with children or vulnerable adults the non-existence of a substantiated allegation of abuse, neglect or exploitation by verifying that fact though (a) as to vulnerable adults, the Adult Abuse Registry maintained by the Department of Disabilities, Aging and Independent Living and (b) as to children, the Central Child Protection Registry (unless the Party holds a valid child care license or registration from the Division of Child Development, Department for Children and Families). See 33 V.S.A. §4919(a)(3) and 33 V.S.A. §6911(c)(3).

***Reporting of Abuse, Neglect, or Exploitation.*** Consistent with provisions of 33 V.S.A. §4913(a) and §6903, Party and any of its agents or employees who, in the performance of services connected with this agreement, (a) is a caregiver or has any other contact with clients and (b) has reasonable cause to believe that a child or vulnerable adult has been abused or neglected as defined in Chapter 49 or abused, neglected, or exploited as defined in Chapter 69 of Title 33 V.S.A. shall: as to children, make a report containing the information required by 33 V.S.A. §4914 to the Commissioner of the Department for Children and Families within 24 hours; or, as to a vulnerable adult, make a report containing the information required by 33 V.S.A. §6904 to the Division of Licensing and Protection at the Department of Disabilities, Aging, and Independent Living within 48 hours. Party will ensure that its agents or employees receive training on the reporting of abuse or neglect to children and abuse, neglect or exploitation of vulnerable adults.

9. **Information Technology Systems**:

***Computing and Communication***: Party shall select, in consultation with the Agency of Human Services' Information Technology unit, one of the approved methods for secure access to the State's systems and data, if required. Approved methods are based on the type of work performed by the Party as part of this agreement. Options include, but are not limited to:

1. Party's provision of certified computing equipment, peripherals and mobile devices, on a separate Party's network with separate internet access. The Agency of Human Services' accounts may or may not be provided.

2. State supplied and managed equipment and accounts to access state applications and data, including State issued active directory accounts and application specific accounts, which follow the National Institutes of Standards and Technology (NIST) security and the Health Insurance Portability & Accountability Act (HIPAA) standards.

***Intellectual Property/Work Product Ownership*:** All data, technical information, materials first gathered, originated, developed, prepared, or obtained as a condition of this agreement and used in the performance of this agreement -- including, but not limited to all reports, surveys, plans, charts, literature, brochures, mailings, recordings (video or audio**)**, pictures, drawings, analyses, graphic representations, software computer programs and accompanying documentation and printouts, notes and memoranda, written procedures and documents, which are prepared for or obtained specifically for this agreement, or are a result of the services required under this grant -- shall be considered "work for hire" and remain the property of the State of Vermont, regardless of the state of completion unless otherwise specified in this agreement. Such items shall be delivered to the State of Vermont upon 30-day's notice by the State. With respect to software computer programs and / or source codes first developed for the State, all the work shall be considered "work for hire," i.e., the State, not the Party (or subcontractor or sub-grantee), shall have full and complete ownership of all software computer programs, documentation and/or source codes developed.

Party shall not sell or copyright a work product or item produced under this agreement without explicit permission from the State of Vermont.

If Party is operating a system or application on behalf of the State of Vermont, Party shall not make information entered into the system or application available for uses by any other party than the State of Vermont, without prior authorization by the State. Nothing herein shall entitle the State to pre-existing Party's materials.

Party acknowledges and agrees that should this agreement be in support of the State's implementation of the Patient Protection and Affordable Care Act of 2010, Party is subject to the certain property rights provisions of the Code of Federal Regulations and a Grant from the Department of Health and Human Services, Centers for Medicare & Medicaid Services. Such agreement will be subject to, and incorporates here by reference, 45 CFR 74.36, 45 CFR 92.34 and 45 CFR 95.617 governing rights to intangible property.

***Security and Data Transfers:*** Party shall comply with all applicable State and Agency of Human Services' policies and standards, especially those related to privacy and security. The State will advise the Party of any new policies, procedures, or protocols developed during the term of this agreement as they are issued and will work with the Party to implement any required.

Party will ensure the physical and data security associated with computer equipment, including desktops, notebooks, and other portable devices, used in connection with this Agreement. Party will also ensure that any media or mechanism used to store or transfer data to or from the State includes industry standard security mechanisms such as continually up-to-date malware protection and encryption. Party will make every reasonable effort to ensure media or data files transferred to the State are virus and spyware free. At the conclusion of this agreement and after successful delivery of the data to the State, Party shall securely delete data (including archival backups) from Party's equipment that contains individually identifiable records, in accordance with standards adopted by the Agency of Human Services.

Party, in the event of a data breach, shall comply with the terms of Section 7 above.

10. **Other Provisions**:

***Environmental Tobacco Smoke.*** Public Law 103-227 (also known as the Pro-Children Act of 1994) and Vermont's Act 135 (2014) (An act relating to smoking in lodging establishments, hospitals, and child care facilities, and on State lands) restrict the use of tobacco products in certain settings. Party shall ensure that no person is permitted: (i) to use tobacco products or tobacco substitutes as defined in 7 V.S.A. § 1001 on the premises, both indoor and outdoor, of any licensed child care center or afterschool program at any time; (ii) to use tobacco products or tobacco substitutes on the premises, both indoor and in any outdoor area designated for child care, health or day care services, kindergarten, pre-kindergarten, elementary, or secondary education or library services; and (iii) to use tobacco products or tobacco substitutes on the premises of a licensed or registered family child care home while children

are present and in care. Party will refrain from promoting the use of tobacco products for all clients and from making tobacco products available to minors.

Failure to comply with the provisions of the federal law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity. The federal Pro-Children Act of 1994, however, does not apply to portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, & Children (WIC) coupons are redeemed.

***2-1-1 Database:*** If Party provides health or human services within Vermont, or if Party provides such services near the Vermont border readily accessible to residents of Vermont, Party shall adhere to the "Inclusion/Exclusion" policy of Vermont's United Way/Vermont 211 (Vermont 211), and will provide to Vermont 211 relevant descriptive information regarding its agency, programs and/or contact information as well as accurate and up to date information to its database as requested. The "Inclusion/Exclusion" policy can be found at www.vermont211.org.

***Voter Registration***: When designated by the Secretary of State, Party agrees to become a voter registration agency as defined by 17 V.S.A. §2103 (41), and to comply with the requirements of state and federal law pertaining to such agencies.

***Drug Free Workplace Act:*** Party will assure a drug-free workplace in accordance with 45 CFR Part 76.

***Lobbying***: No federal funds under this agreement may be used to influence or attempt to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendments other than federally appropriated funds.

# Northeast Kingdom Council on Aging

# Care & Support Standards 2025

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# Northeast Kingdom Council on Aging

## Individual Care & Support Standards

This program description serves as the 2025 Case Management Program Description for NEKCOA. This document is maintained by the Directors of Care and Support and is reviewed and updated annually in collaboration with the Care and Support Dept and Executive Director.

The Care and Support department encompasses Case Managers, Options Counselors, Information and Referral (Helpline) Staff, and Transitions Coordinator. Often clients enter the system through the helpline and may be referred depending upon screening for ongoing Case Management Services.

**Case Management Eligibility**

In order to qualify for case management services an individual must be a Vermonter 60+ or a younger adult that is enrolled in a Choices for Care, Long Term Medicaid or Moderate Needs program and those served thru the Older Americans Act.

All eligible individuals are then screened for the following:

1. Individuals who are referred by community partners, families, caregivers or themselves and want our services.
2. Individuals with complex health conditions or needs whether acute or long-term.
3. Individuals who are experiencing homelessness have at least one complex physical, behavioral, or developmental health need.
4. Individuals who are considered high utilizers of care, including those who have had 3+ emergency department visits or an unplanned hospital or short-term skilled nursing facility says in the last 6 months, or those who have been identified by the state/health plan as having a pattern of high utilization that could have been avoided.
5. Adults with serious mental illness or substance use disorder who are experiencing at least one complex social factor and meet additional criteria.
6. Individuals transitioning from incarceration, or who have transitioned from incarceration within the past 12 months, who also have certain medical conditions.
7. Individuals at risk for institutionalization and eligible for Long-Term Care services.
8. Nursing facility residents who want to transition to the community and are strong candidates for a successful transition
9. Individuals managed under a prior case management contract and being transitioned to the agency.

**Program Services**

The NEKCOA provides the following services to individuals enrolled in case management:

- Options Counseling
- SHIP (State Health Insurance Program) Counseling
- Comprehensive case management
- In-home care referrals-(SASH, home health agencies, transportation, VDC)
- Behavioral and mental health service coordination through the Eldercare and collaboration with NKHS programs
- Care coordination (VCCI, Community Connections, home health agencies, mental health agencies, VT Assistive Technology, VABVI, nursing homes, HireAbility BIAVT
- Health promotion-Wellness Center, Nutrition counseling, Wellness programs in house, CHT
- Comprehensive transitional care-(developing new position) and/or referrals to MFP
- Individual, caregiver and family support-Caregiver support
- Community and social support services referrals, including housing and volunteer services (Legal Aid, Community Action (NEKCA) NETO, USDA, VCIL, grant programs HomeShare, Journey to Recovery
- Caregiver support services and access to grants.

**Choices for Care Case Management:**

NEKCOA collaborates with individuals and their family/caregivers to develop a comprehensive, individualized, person-centered, and culturally appropriate care plan. Comprehensive case management services include, but are not limited to:

- Engaging the client in case management that is person-centered and follows the specific goals and plan outlined in the Shared Decision plan, which is created by the client and the Case Manager. The Shared Decision Plan incorporates the needs of the client in areas of physical health, mental health, substance use disorder, community-based long-term care services and supports (Choices for Care Long-Term Medicaid High/Highest and Moderate Needs Programs), palliative care, trauma-informed care needs, social supports, and housing needs. This plan is updated annually.
- Assessing the client's unmet needs using screening tools and assessments, specifically the Independent Living Assessment (ILA). The ILA is also used to complete a comprehensive health risk assessment to identify the client's physical and mental health, substance use, palliative, and social service needs. The pace of this work is set by the client.
- Providing the client with the necessary tools and supports to be able to engage effectively with health and service providers, including primary care physicians and home health agencies.
- Supporting the achievement of the client's self-directed, individualized health and social goals to be able to improve their functional, social or health status and working with the client to identify their strengths and barriers related to improving the health status. This is done through the completion of the Shared Decision Plan.
- Providing care coordination while clarifying roles and responsibilities of a multi-disciplinary team,

including community partners, primary care physicians, mental health clinicians, the client and their family and caregiver.

- Coordinating and collaborating with all the clients of the client's care team, including care providers, to promote continuity and consistency of care and to ensure that the client's goals and direction are being followed.
- Identifying the best form of communication for the client, including phone calls, video calls, in-person visits in the client's home or the case manager's office, community space, direct mail, emails.
- Providing excellent information and support related to questions and issues related to Medicare, Medicaid, and other health insurance programs.
- Work effectively with clients to identify any unmet needs related to mental health. When identified and with the approval of the client, referrals are made to The Eldercare Clinician or NKHS.
- Provide support for caregivers and clients through the use of the Dementia Respite Grant (DRG) or Family Caregiver Grant, support groups, Trualta, TCare, referrals for counseling.

**Care Coordination:**

Care coordination services begin once the care plan is developed. NEKCOA works with clients to identify who is a part of the client's care team such as their Primary Care Provider (PCP), specialists, caregiver, family clients, or case managers through housing agencies. With the approval of the client NEKCOA works to keep care team clients informed of client's goals. Care coordination may include case conferences in order to ensure that the client's care is continuous and integrated among all providers, as applicable. Care coordination services include, but are not limited to:

- Working with the client to implement their care plan.
- Assisting the client in navigating health, behavioral health, and social services systems, including housing and interpreting documents at a level that is understandable for the client.
- Sharing options with the client for accessing care and providing information to the client regarding care planning.
- Identifying barriers to the client's treatment and medication management adherence.
- Monitoring and supporting treatment adherence (including medication management and reconciliation), coordinating with care team for strategies and services.
- Assisting in the attainment of the client's goals as described in the care plan .
- Encouraging the client's decision making and continued participation in case management.
- Participates in care coordination meetings.
- Monitoring referrals, coordination, and follow ups to ensure needed services and support are offered and accessed.
- Sharing information with all involved parties to monitor the client's conditions, health status, care planning, medications usages and side effects.
- Creating and promoting connections to other services and supports.

- Helping facilitate communication and understanding between clients and healthcare providers.
- Additional Case Management support is provided by the transitions coordinator in facilitating communication with community partners for those transitioning from onesetting to another.

**Health Promotion:** NEKCOA encourages and supports case management clients to make lifestyle choices based on healthy behavior, with the goal of motivating clients to successfully monitor and manage their health. Clients will develop skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions. The health promotion services shall include, but not be limited to:

- Encouraging and supporting health education for the client and family/support persons.
- Exercise classes including Bone builders, Falls prevention Tai Chi, Golden Ball Tai Chi, Arthritis foundation Exercises
- Offering Nutritional counseling with referrals to registered dietician
- Linking the client to resources for smoking cessation; management of chronic conditions; self-help recovery resources; and other services based on client needs and preferences.
- Using evidence-based practices, such as motivational interviewing, to engage and help the client participate in and manage their care.

**Transitional Care:**

NEKCOA provides transitional care, which includes services to facilitate client's transitions from and among treatment facilities, including admissions and discharges. In addition, comprehensive transitional care reduces avoidable admissions and readmissions. The comprehensive transitional care services will include, but not be limited to:

- Collaborating, communicating, and coordinating with all involved parties.
- Easing the client's transition by addressing their understanding of rehabilitation activities, self-management activities, and medication management.
- Planning appropriate care and/or place to stay post-discharge, including temporary housing or stable housing and social services.
- Arranging transportation for transitional care, including to medical appointments.
- Developing and facilitating the client's transition plan.
- Endeavoring to prevent potentially avoidable admissions and readmissions and tracking avoidable admissions and readmissions.
- Evaluating the need to revise the client's case management plan.
- Providing transition support to permanent housing.

**Individual and Family Support Services:**

NEKCOA provides individual and family support services that include activities that ensure the client and family/support persons are knowledgeable about the client's conditions with the overall goal of improving client's adherence to treatment and medication management. Individual and family support services also involve identifying supports needed for the client and family/support persons to manage the client's condition and assisting them to access these support services. Individual and Family Support Services include, but are not limited to:

- Assessing the strengths and needs of the client and family/support persons through TCare, Trualta.

- Linking the client and family/support persons to peer support and/or support groups to educate, motivate and improve self-management. Including Alzheimer's Association, and Trualta for education and training.
- Connecting the client to self-care programs to help increase their understanding of their conditions and care plan.
- Promoting engagement of the client and family/support persons in self-management and decision making.
- Determining when client and family/support persons are ready to receive and act upon information provided and assist them with making informed choices.
- Advocating for the client and family/support persons to identify and obtain needed resources (e.g. transportation) that support their ability to meet their health goals.
- Accompanying the client to team meetings, discharge planning, care management meetings when necessary.
- Identifying barriers to improving the client's adherence to treatment and medication management.
- Evaluating family/support persons' needs for services. Offers care giver grants, if eligible, to meet the needs of the family and care receiver, including Kinship grants for grandparents raising grandchildren.

**Referral to Community and Social Supports**

NEKCOA provides appropriate services to meet the needs of clients, assists in identifying and referring clients to available community resources, and follows up with all clients. Some of the services provided by NEKCOA include assistance with applications for government benefits such as Medicare, MSP, 3SQ and fuel assistance, and referrals for unemployment benefits.

Information and referral staff, options counselors and case manager

NEKCOA assists clients in applying for additional benefits including:

- Supplemental Nutrition Assistance Program (SNAP),
- State Health Insurance Programs such as MSP (Medicare savings programs) Extra Help, VPharm
- Low Income Home Energy and Heating Assistance Programs (LIHEAP-fuel assistance)
- In Home Support Services (IHSS)
- Applying for Essential Persons, Attendant Services, Medicaid
- Housing and Weatherization Programs

NEKCOA also helps to connect clients with food pantries, transportation services, and low-income housing. NEKCOA works collaboratively with landlords for people who are at risk of eviction, refers clients to legal aid as appropriate, completes housing assessments.

Community and social supports referral services include, but are not limited to:

- Identifying the client's community and social support needs.
- Identifying resources and eligibility criteria for housing, food security and nutrition, employment counseling, childcare, community-based LTSS, school and faith-based services, and disability services, as needed and desired by the client.
- Providing client with information on relevant resources, based on the client's needs and interests.

- Actively engaging appropriate referrals to the needed resources, access to care, and engagement with other community and social supports.
- Following up with the client to ensure needed services are obtained.
- Coordinating services and follow-up post engagement.
- Checking in with the clients routinely through in-person or telephonic contacts to ensure they are accessing the social services they require.
- Providing services that support an individual's ability to prepare for and transition to housing and providing services that support the individual in being a successful tenant in their housing arrangement and thus able to sustain tenancy.

**Case Management Care Coordination**

NEKCOA case management coordination involves organization of the client's care needs and implementation of the case management plan in order to improve client outcomes. At times the Transition Coordinator, Options Counselor, or Helpline may assist with coordination in an effort to ensure timely response.

The Case manager coordinates and collaborates with all involved parties to promote continuity and consistency of care and works to clarify roles and responsibilities of the multi-disciplinary team, providers, the individual, and family/support persons. Through our referral process, NEKCOA can accept referrals into options counseling and/or case management from other agencies and services if they are working with a client who could benefit from the program. We have different ways for agencies or partners to refer:

- Calling the helpline
- Utilizing our fillable referral form and sending electronically
- Emailing the helpline or supervisor
- Through Community Partners meetings

The case manager advocates on behalf of the client with other health care professionals, and facilitates communication and understanding between the individual and their healthcare providers. The case manager may assist clients in finding ways to get people to doctor's visits, to food banks, and local non-profits to receive services. When in-person visits are not possible NEKCOA will conduct three-way phone calls and video calls, communicate via email, and send applications to coordinate services with other entities.

NEKCOA works very closely with:

- Doctor's offices
- Nursing homes
- CAP agencies
- SASH-Supports and Services in the Home
- Housing agencies
- Home health agencies
- Mental health agencies
- State entities (DAIL, DVHA, ESD)

Case managers document all referrals in case records and establish follow-up dates in order to evaluate whether the referral took place and was helpful to the individual. The individual may request a change including not wanting to work with a referral and the case manager will document that preference.

NEKCOA case managers work closely with peers, program support staff, and supervisors to ensure that services are provided according to the high standards and evidence-based best practices of the organization. Case managers meet regularly with their supervisors in one-on-one sessions to discuss high-complexity cases and to evaluate the successes and challenges they have encountered. The team meets monthly for additional program oversight and to share new best practices within the team. Leadership conducts periodic auditing of case assessments and action plans and issues regular reports to organizational leadership.

**Program Evidence and Professional Standards**

NEKCOA uses research-based evidence, clinical expertise and the values and preferences of its clients to guide the decision-making processes in case management. We understand the importance of using qualitative and quantitative data, current evidence, and professional standards to develop and assess the effectiveness of the program. DAIL/State of VT reviews evidence related to its programs by monitoring appropriate publications, websites, and clientship organizations for new research findings and best practices.

A. Process and Approach

NEKCOA conducts this systematic review on an annual basis. The review is led by the AAA network committee and involves at least one registered nurse and a licensed social worker. The review and recommendations are then developed in coordination with VAST (VT Area Supervisory Team).

The annual review includes an overall evaluation of key program materials – this systematic review of program materials and processes includes an assessment of alignment with current evidence and professional standards as well as an assessment of program content for cultural and linguistic appropriateness.

The reviewer documents the recommendations which include specific references to:

- Whether materials for individuals are consistent with evidence and standards and if not what changes need to be made.
- Whether training materials are consistent with evidence and standards and if not what changes need to be made.
- Whether materials are culturally and linguistically appropriate and what adjustments or additional revisions need to be made.

B. Evidence and Information Sources

Sources of evidence, professional standards and educational handout material used by NEKCOA for case management may include, but are not limited to:

- Materials published by recognized authorities such as the Vermont Department of Health Access
- (DVHA) and the Vermont Agency of Health Services
- The DVHA Clinical Practice Guidelines which include published and maintained guidelines for:
    - ABA

- Asthma
- Cardiovascular
- Depression
- Developmental Screening
- Diabetes
- Rehab PT/OT/ST
- Substance Use Disorder and Opioid Treatment
- Transcranial Magnetic Stimulation

- The Centers for Disease Control and Prevention (CDC).
- Textbooks in current use by graduate professional schools, e.g. social work, nursing, or gerontology.

- Nutrition resources and guidelines.
- Material promulgated by key national organizations addressing the needs of a particular population, e.g., Alzheimer's Association or Arthritis Foundation.

- Corroborated research published in peer-reviewed journals/pamphlets/educational materials relating to similar populations.

- Standards and training materials published by universities and national professional associations, e.g., National Association of Social Workers and Case Management Society of America (CMSA).

- Foundations dedicated to serving older adults such as The John A. Hartford Foundation and The SCAN Foundation.

- Training and resource information provided by individual health plan providers, V4A, DAIL, etc.

C. Ensuring Program Content Consistent with Evidence and Professional Standards

1. Program content is reviewed against current evidence and standards annually, or more frequently if new evidence and/or standards are provided by the individual health plan providers. The Aging Service Director and/or Case Management Supervisors will create a report based on their review to the AAA Network Committee. This report will be used to make adjustments to the program if found to be out of alignment. It is the responsibility of Aging Service Director to ensure that all staff have been provided with the most current information and tools necessary to provide high-quality care and promote quality outcomes.
2. Educational and handout materials used to help individuals manage their conditions are obtained from current evidence-based resources such as the CDC, DHCS and individual health plan providers.
3. Staff training materials are developed or revised using evidence-based tools from sources including, but not limited to, government organizations, professional organizations, and the individual health plans. The Aging Service Director and/or Case management Supervisors are responsible for the development of the training program and ensuring that the material presented is current best practice. Examples of staff training include: Behavioral change models/Motivational Interviewing, Boundaries & Self-Care, Mandated Reporting, and Effective Goal Writing. Additional training is planned for: Cultural Sensitivity, Field Safety, Confidentiality, and Health Literacy. Attendance will be tracked by the Case Management supervisors at all staff training.

4. The program is reviewed for cultural and linguistic appropriateness to ensure the following:
   a. The diverse needs of the patient population are addressed.
   b. The care team is able to communicate with the patient and caregiver.
   c. Care team clients understand that distinct ethnic groups may have different beliefs, values, and behaviors.

A report will be created based on the review and presented to AAA Network Committee and VAST Team. This report will be used to make adjustments to the program if found to be out of alignment.

**Promoting Health Equity**

Throughout its history as an organization, NEKCOA has served a vulnerable, multi-cultural and diverse population. Ensuring health equity is at the core of our mission, hiring practices, management development, program design and annual initiatives. NEKCOA has adopted the WHO definition of health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically."

NEKCOA is committed to improving health equity in our communities. The following summarizes planned ongoing and 2025 new actions related to health equity.

- Annually- the outward-facing recruitment material will be reviewed and updated as necessary to assure for DEI by HR and the management team. The annual review will assist the agency in recruiting, hiring, and onboarding diverse staff.
- All staff will complete the Civil Rights Training as required by DAIL by the end of 2025.
- The training will be completed during onboarding or annually for tenured staff.
- Websites will be updated regularly to expand access to understanding of available resources to a wide range of populations.

# Policy Standards:

**C&S Policy 1: Case Management Plan for a person-centered approach**

**Purpose:**

NEKCOA provides comprehensive, person-centered case management services to clients. As part of the case management program, NEKCOA provides services that are person-centered and designed to meet the needs and priorities of the individual while supporting their medical, social, psychological and functional needs. A care plan is developed for each client that reflects their individual needs, priorities and community resources.

**Policy:**

NEKCOA develops, manages and maintains individualized and person-centered care plans as part of the case management process. NEKCOA is responsible for working with clients and their caregivers and medical team to develop and implement a care plan that reflects their personal needs and priorities. The approach to developing the care plan is based on person-centered care planning which involves viewing, listening to and supporting individuals, based on their strengths, abilities, aspirations and preferences, to make decisions for maintaining a life that is meaningful to them. The resulting care plan reflects the goals and interests of the client and involves them to the level in which they are interested in being involved.

**C&S Policy 1A: Consumer Rights and responsibilities**

**Purpose:**

NEKCOA will maintain a process through which the organization informs participants of their rights and responsibilities while enrolled in case management services. This policy and procedure describes the content of the rights information and the process for distribution with individuals.

**Policy:**

NEKCOA will provide individuals with information related to their rights and responsibilities in an easily understandable format. All rights and responsibilities are clearly explained, and abbreviations and acronyms are defined. The NEKCOA process for communicating the rights and responsibilities of participants will ensure compliance with regulatory requirements. NEKCOA may distribute this information to individuals by mail, fax, email or in person. NEKCOA will mail or provide the information in person to individuals who do not have fax, email, or internet access.

**C&S Policy 1B: Critical Incident Management**

**Purpose:**

The purpose of this policy is to ensure NEKCOA effectively responds to critical incidents through the appropriate use of resources. Effective management of critical incidents can assist in minimizing the negative impact of an unexpected event.

**Policy:**

Critical incidents are events or occurrences that cause harm to an individual or LTSS provider, or that indicate risk (e.g., abuse, neglect, exploitation) to an individual or LTSS provider's health or welfare.

Any person who becomes aware of a critical incident is responsible for reporting the incident. Before reporting an incident, measures must be taken immediately to safeguard the participant/employee. This may include calling 911, contacting Adult Protective Services (APS), contacting Child Protective Services (CPS), law enforcement, fire department or other authorities as appropriate.

Examples of critical incidents include, but are not limited to:

- Abuse, including physical, emotional/verbal, or sexual
- Neglect, including self-neglect, or abandonment
- Exploitation, including financial, coercion, or fraud
- Suicide attempts or threats

- Serious threat of violence to another
- Serious injury
- Any situation that *could* result in injury or potential liability such as environmental safety hazards or carelessness
- Thefts or property damage identified in the course of workplace duties.
- Employee actions that jeopardize safety

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- Serious threat of violence to another
- Serious injury
- Any situation that *could* result in injury or potential liability such as environmental safety hazards or carelessness
- Thefts or property damage identified in the course of workplace duties.
- Employee actions that jeopardize safety.

**C&S Policy 2: Demographic data collection**

NEKCOA collects, analyzes, stores and protects population and individual demographic data for use in assessing the needs of populations and individuals enrolled in programs. All data collection and use is conducted in accordance with client, accreditor and regulator requirements and in compliance with NEKCOA's data confidentiality, management and protection policies and procedures.

This policy describes the specific processes and procedures used in demographic data collection, use and management.

**C&S Policy 2A: Privacy Protections for Data**

**Purpose:**

NEKCOA provides protection of all healthcare data including information on race/ethnicity and language. This policy and procedure describes the processes and requirements.

**Policy:**

NEKCOA maintains processes to protect the privacy of participants through policies related to protected health information (PHI), informational technology security (ITS) and Health Insurance Portability and Accountability Act

(HIPAA). This policy and associated processes also include management of information related to race/ethnicity and language in addition to PHI. All references to processes and protection of PHI extend to information on race/ethnicity and language.

All data and information is subject to privacy and protection requirements in relevant NEKCOA data and information and technology policies. See attachment 3 for procedure.

**C&S Policy 3A: Care and Support Department Staffing Needs and Requirements**

**Purpose:**

NEKCOA ensures that case management staffing levels and licensure requirements support appropriate program expertise and service levels and meet regulatory standards and guidelines.

**Policy:**

It is the policy of NEKCOA to define staffing needs and licensure requirements and use those requirements to evaluate staffing and guide hiring practices. This policy and procedure defines the categories of staff required to support case management, which roles require licensure and the levels of staffing required.

**C&S Policy 3B: LTSS Providers Requirements and Resources**

**Purpose:**

NEKCOA ensures safe and supportive services to participants by referring to long-term support services (LTSS) providers are qualified, screened and supported in their role.

**Policy:**

LTSS providers are paid and unpaid people and organizations that provide long-term services and support. NEKCOA verifies the statuses of all employees and entities or persons who conduct business on behalf of NEKCOA. Verification is conducted in accordance with credentials, competencies, professional standing, and federal exclusionary lists in order to maintain compliance with regulatory and industry standards. This policy describes the processes for defining qualifications, conducting screening and background checks and providing support and assistance to LTSS providers.

**C&S Policy 3C: LTSS Provider Requirements and Resources**

**Purpose:**

NEKCOA ensures appropriate clinical involvement in case management and provides referral processes that support (LTSS) providers. These processes include reinforcement of the role of the primary care and treating provider teams in meeting the clinical needs of participants.

**Policy:**

Case management and support of LTSS participants requires assessing and understanding the participants needs and then coordinating with a broad set of clinical and non-clinical services to address those needs. There are instances in the assessment, care planning and monitoring process where it is appropriate to involve a licensed clinical professional or

notify and/or refer the participant to a clinical professional. This policy and procedure describes the circumstances where a licensed clinical professional is required and the processes for involving or referring to a licensed clinical professional. The policy was developed with the input of a licensed clinical professional and is reviewed and updated by a licensed clinical professional.

**C&S Policy 4: Case Management Assessment**

**Purpose:**

NEKCOA provides comprehensive, person-centered Choices for Care and Older Americans Act case management services to clients. A key step in care planning is to conduct an initial screening of the client's needs and a comprehensive assessments that provide information on the clinical, functional, psychosocial, social needs and physical needs of the client. The information from this assessment process is then used to develop the care plan and involve the appropriate services and support.

**Policy:**

NEKCOA conducts assessments that address health, functioning and communication preferences of the clients. The assessment process also includes an evaluation of current resources and resource needs to identify gaps or adjustments that are required.
This policy describes the specific processes and procedures used in the case management assessment process, including how the assessments are documented and the process for confirming the completion of the assessment.

**C&S Policy 5: Transitions of Care**

**Purpose:**

NEKCOA monitors care transition events in order to support participants as they move from one care setting to another, such as to or from independent home living, acute care, emergency department, skilled nursing facility, custodial nursing facility, or rehabilitation facility. NEKCOA coordinates needed services for participants enrolled in case management programs. These services are provided on both a short-term and long-term basis and include supporting participants as they move from one level of care and independence to another. The focus is to keep individuals independent in their own homes if that is what they prefer while addressing needs that may emerge and require other levels of care or service. NEKCOA provides care transition processes that support continuity of care, service, and information.

**Policy:**

Care transitions are when participants move between care settings (e.g., from home to hospital) as their condition and care needs change during the course of a chronic or acute illness. Participants who are experiencing transitions are particularly vulnerable to receiving fragmented and unsafe care if transitions are poorly coordinated. NEKCOA transitions coordinator and case management services serve a key role in ensuring that information, care and services are coordinated and participants and caregivers are kept supported and informed. Transitions may be planned or unplanned. Planned transitions include elective surgery or a decision to enter a long-term care facility. Unplanned transitions include sudden hospitalizations or the use of the emergency from resulting from emergencies and urgent needs.

Transitions span any care setting that involves a provider or place that delivers health care and health-related services, and includes:

- Acute care facilities.
- Emergency departments.
- Skilled nursing facilities.
- Custodial nursing facilities.

- Rehabilitation facilities.
- The home and community.

The receiving setting is the setting responsible for care after a transition and the case management program and care managers are responsible for coordinating across the entire continuum and span of the transition. Additionally, we have a transition coordinator to ensure that clients receive the support needed for transitions.
NEKCOA maintains a process to monitor and identify client care needs and/or problems that may contribute to unplanned transitions and provides community-based assistance when transitions occur. This policy describes the specific processes and procedures used to support safe transitions of care.

**C&S Policy 6: Case Management Staff Training**

**Purpose:**

NEKCOA ensures case management staff receive initial and ongoing training that supports provision of comprehensive and quality case management and care management services to all AGENCY program participants. These processes include confidentiality and privacy training as well as skills and program processes.

**Policy:**

Comprehensive initial and ongoing training is crucial to ensuring case management team members are informed and supported in their work providing care and case management to participants. This policy and procedure describes the subjects, scope and focus of the training that is provided. The training may include NEKCOA developed materials as well as training provided by other programs, NEKCOA and regulators.

**C&S Policy 7: Complaint Management**

**Purpose:**

NEKCOA is committed to delivering high quality services that meet participant needs within the scope of each program and benefit structure. If a participant, their families, or an advocate has concerns or if there is dissatisfaction with services provided by NEKCOA staff or a third-party vendor performing services on behalf of NEKCOA, a complaint or grievance can be filed with the agency. This policy describes the process and timeframes for responding appropriately to complaints.

**Policy:**

NEKCOA maintains processes to inform participants of; 1) their right to communicate complaints or grievances, 2) the process to communicate complaints or grievances and 3) their right to receive a timely response.

Complaints or grievances from participants, family members or caregivers are received through written (electronic or mail) or verbal communication. All complaints or grievances - regardless of severity, duration, and type - shall be acknowledged, reviewed, investigated, and resolved according to NEKCOA policies and procedures. Standards prohibit the filtering of client complaints based on staff perceptions or prior experiences. The investigative process will include reviewing the substance of the complaint and/or grievance along with any aspect of care involved. The investigative process is focused not on blame but on resolution and improvement. All complaints and grievances will be monitored for trends and opportunities for improvement. Any complaint involving potential or actual safety related issue must be addressed immediately and reported to the department management, Quality Department, and any mandatory reporting agencies. Any complaint involving a violation of Patient Rights and Responsibilities must be addressed immediately and reported to department management and the Quality Department.

**Complaint:**

An oral or written expression of dissatisfaction with services or behavioral interactions. Dissatisfaction is often resolved through informal means at the time of service or within 5 business days.

**Grievance:**
An escalation of an unresolved complaint or dispute expressing dissatisfaction with operations, services, products, activities, relationships, or behavior of the organization or any of its staff, interns, volunteers, or third-party vendors. While complaints are resolved by the department serving the patient/client, grievances involve coordination with the Quality Department, and their resolution must be reviewed by senior departmental or executive staff**.** All verbal or written complaints of abuse, neglect, patient harm, or the risk of patient harm by an employee or third-party vendor, or a violation of the Patient Rights and Responsibilities are considered grievances and must be immediately reported upon first awareness. Any verbal or written complaint from a family to treat a complaint like a grievance will be considered grievance.

**Resolution**:
A complaint or grievance is considered resolved when a solution to the initiating concern has been implemented, or in cases where a complete solution is not possible, remediating efforts have been applied to address the participants or representative/caregiver's concerns and are acceptable to all parties involved.

A. Mandated Reporting of Abuse, Neglect, and Exploitation Policy

*In accordance with state law, 33V.S.A. 6903, all employees who work regularly with vulnerable adults and who know of, or have received information about abuse, neglect, exploitation of such adult, or have reason to suspect such adult has been abused, neglected or exploited shall report or cause a report to be made within 48 hours. To file a report, contact the Adult Protective Services Division of the Department of Disabilities, Aging and Independent Living. Employees are encouraged to speak to a supervisor prior to filing a report.*

NEKCOA Reporting Procedure:

A mandated reporter does not have to prove or be certain that a vulnerable adult has been abused, neglected or exploited in order to make a report. The reporter only needs to have reason to believe that abuse, neglect and or exploitation may have occurred or is still occurring.

When abuse, neglect or exploitation of a vulnerable adult is suspected, witnessed or reported by a third party, NEKCOA employees need to make a report within 48 hours, preferably with the vulnerable adult's knowledge, but with or without the consent of the individual while also informing supervisor. Documentation should reflect such.

Reports can be made orally, in writing/fax, or by the use of the online reporting form to the Commissioner or his designee, Adult Protective Services (APS).

NEKCOA employees should have readily available:

APS toll free phone number: 1-800-564-1612; APS fax number: 1-802- 241-4092.

Mailing address:
State of Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living

Adult Services Division
280 State Drive, HC2 South
Waterbury, VT 05671-2070
Website: www.dlp.vermont.gov/protection

**Emergency situation:** If the C&S staff member believes the client is in danger of imminent harm, the staff member should call 911 if able to or remove his-/herself from the situation to do so. Following the 911 call the C&S staff member should contact the appropriate supervisor or Executive Director at the agency immediately.

B. SELF-NEGLECT POLICY

The C&S staff member shall recognize Self-Neglecting behaviors and offer intervention when such behaviors jeopardize the client's well-being. For adults age 60 and older, a referral shall be received by NEK Council on Aging.

Definition of Self – Neglect as finalized by the DAIL Self-Neglect Task Force:
"The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one's own financial affairs. This definition excludes people who make a conscious and voluntary choice not to provide for certain basic needs as a matter of life style, personal preference or religious belief and who understand the consequences of their decision. This means that an older Vermonter who is capable of making decisions and understanding the impact of their decisions may choose to live in a way that negatively impacts their well- being. That is their choice, and they are not self- neglecting."

**Procedure:**
When a client appears to be demonstrating such behaviors, a self-neglect risk assessment will be completed. Upon completion of the risk assessment the case shall be reviewed with a supervisor to determine a plan of action. Once review has been completed the staff members will work to establish goals and a plan to address the needs of the client.

**NOTE: Persons under the age of 60 are referred to the AHS Field Director for intervention**.

C. Client Record Policy

Client records are to be stored and maintained electronically, and a hard copy file may also exist. All records will be created and maintained in a manner that will protect client security, integrity, confidentiality, and allow appropriate access by authorized NEKCOA staff members.

All written/hard copies of records pertaining to clients will be maintained in a secured area with at least two locked points prior to access. Records held electronically on databases will be password protected, and the database itself will also be password protected.

The C&S staff member may disclose information without consent in limited circumstances. See Mandated Reporting policies. HIPAA is not meant to inhibit information gained through care coordination.

The C&S staff must adhere to the following policies when releasing information and be guided by the most restrictive mandate:

Older American Act,
AHS Rule 96-1. It also is known as AHS Rule 96-23
Vermont AHS #08-048 Consumer Information and Privacy Rule. Effective 1/1/09 HIPPA
42 CFR Part 2
12 VSA 1612
Title 9 Vermont Statues Annotated Ch. 62

Records relating to the delivery and documentation of Care & Support services will be securely and confidentially stored for 3 (three) years and maintained until securely destroyed.

D. Wait List Policy

When circumstances require it, wait lists may be created to assure that both new and existing clients will receive services based on their needs, once those services become available. When a decision is made to utilize a wait list, the Director of Care & Support Services will screen only new referrals affected by the wait list based on the following criteria. See prioritization as listed above as well.

E. Confidentiality Policy

No information about a client may be disclosed in a way that identifies the client unless:

- The client or her/his legal representative has provided informed consent.
- Disclosure is ordered by a court, with subpoena provided.
- Disclosure of suspected abuse, neglect or exploitation to Adult Protective Services is required as a Mandated Reporter.

Before disclosing client information or that the client works with NEKCOA, the C&S staff member will obtain written authorization from the client or his/her legal representative. Under some circumstances, verbal permission may be granted by the client or his/her legal representative over the phone. In these circumstances, the C&S staff member will document the verbal consent and date on the release. The C&S staff member will obtain a written signature at the next available opportunity, and will provide copies of the release to the client and/or his/her legal representative.

Even with permission to share information, NEKCOA staff should be guided by the following AHS rule: *"Under all circumstances, all Individually Identifiable Information Shared among Employees, Contractors and Grantees who are involved with providing services to the Consumer, or who will administer those services, will be shared on a Need-to -Know basis." – Agency of Human Services #08-048 -Consumer Information and Privacy Rule, Effective 1/1/09.*

# ACKNOWLEDGEMENT

**(Please sign, date, and return this page to a Care & Support Supervisor)**

I acknowledge that I have received and read NEKCOA's Care & Support (C&S) Standards, and I understand they are the foundation of the work this department performs for the NEKCOA.

Employee's Name (print): _____

Employee Signature: _____

Date: _____


# NEKCOA Care and Support

# Policy Descriptions

| Reference # | Policy Title | | |
|---|---|---|---|
| Policy CS1 | Case Management Plan for person-centered approach | | |
| **Scope** (Optional – Program or Population) | **Department** (Optional) | | |
| **Approval** | **Original Approval Date** | **Last Revision Date** | **Next Revision Date** |
| 8.1.25 | 8.1.25 | | |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA provides comprehensive, person-centered case management services to clients. As part of the case management program, NEKCOA provides services that are person-centered and designed to meet the needs and priorities of the individual while supporting their medical, social, psychological and functional needs. A care plan is developed for each client that reflects their individual needs, priorities and community resources.

**Policy:**

NEKCOA develops, manages and maintains individualized and person-centered care plans as part of the case management process. NEKCOA is responsible for working with clients and their caregivers and medical team to develop and implement a care plan that reflects their personal needs and priorities. The approach to developing the care plan is based on person-centered care planning which involves viewing, listening to and supporting individuals, based on their strengths, abilities, aspirations and preferences, to make decisions for maintaining a life that is meaningful to them. The resulting care plan reflects the goals and interests of the client and involves them to the level in which they are interested in being involved.

NEKCOA recognizes that caregivers who support the client should be actively involved in the plan development process, and they are encouraged to contribute to discussions about goals and other aspects of the process but may not define goals for an individual.

**Procedure:**

1. The case manager completes the assessments as described in the assessment policy. The results of those assessments, along with information provided by the client and their caregiver, are then used to create a case management plan based on the individual's person-centered prioritized goals and preferences. The care plan is documented, reviewed and maintained in the appropriate system. It is completed within 45 days of the client's enrollment and is reviewed and updated at least every twelve months.

2. In order to ensure that the care plan and goals lead to client activation, development of the care plan must follow a person-centered approach. This involves viewing, listening to, and supporting individuals based on their strengths, abilities, aspirations, and preferences. Individuals should be involved in the care planning process, up to the extent they prefer, to ensure that the case management partnership between the client and their caregivers is meaningful to the client. The resulting care plan must reflect the goals and interests of the individual.

3. The care plan includes the following information:

    a) Services needed:

The case manager documents services that the client is already receiving and then uses the results of the assessments that were conducted to identify what existing services should be continued and what new services are suggested for the client. The case manager includes both services that are provided directly by NEKCOA as well as services available through other community-based providers or sources. These services are documented in the shared care plan and stored in the appropriate electronic system.

b) Person-Centered Prioritized goals - The Case Manager works with the client and caregivers to discuss, finalize, prioritize and document the goals for the client that meet SMART criteria and are driven by the client's preferences and choices. The goals are documented in the shared care plan and are prioritized in order of importance as high, medium, or low.

c) Collaborative approaches -
Caregivers, friends and associates and family clients can be important contributors and clients in supporting their client in their shared care plan. The case manager works collaboratively with these resources when developing the care plan. The case manager identifies and documents the role of caregivers, associates and family clients in the shared care plan, including whether and how they are to be included in communications and care planning, and documents consent to do so. The case manager also documents if the client does not have caregiver or family support and evaluates whether to initiate identifying that support as part of the care plan.

d) Identification and assessment of barriers
The case manager identifies and documents barriers that exist to the client's ability to receive and use services appropriately or their ability to participate in the care plan or meet goals. The barriers may change over time and part of the case manager's role is to help understand and address those barriers with the client. The barriers are identified during the assessment and care planning process and are documented. The barrier analysis may assess factors such as:

- Language or literacy level.
- Access to reliable transportation.
- Physical and functioning constraints.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

Questions the case manager may ask or address in their barrier assessment may include:

- Does the individual understand the condition and treatment?
- Does the individual want to participate in the case management plan?
- Does the individual believe that participation will improve health?
- Does the client have any fears or concerns that impede their participation in the plan?
- Are there financial or transportation limitations that may hinder the individual from participating in care?
- Does the individual have the mental and physical capacity to participate in care?

e) Development of a follow-up schedule:
After completion of the care plan and throughout the case management process the case manager identifies and confirms a follow-up schedule with the client. This schedule can include follow-up sessions either by phone or in-person and include support such as:

- Counseling.
- Education for the individual.
- Establishing the frequency of in-person and telephone check-ins.
- Self-management support.
- Determining when follow-up is not appropriate.
- Updating and revising the care plan.
- Confirming the receipt of services or addressing concerns with those services.
    - The case manager documents the next follow-up date and approach (phone, in-home) in the care plan the appropriate electronic system. The case manager is required to conduct follow-up at least every 30 days.

f) Communication with LTSS providers:

LTSS providers are paid and unpaid individuals and organizations that provide LTSS. Case managers are responsible for routinely communicating with LTSS providers and agencies to confirm that services have been ordered, are being delivered and/or are being discontinued or revised. The case manager documents the date of communications, the content and the planned follow-up in the appropriate electronic system. The case manager may also note if the client is having any issues with the LTSS provider. The case manager should follow up on the issues and assist in resolving the situation or changing providers if needed.

g) Establish, communicate and document emergency back-up plans:

The Case Manager is responsible for developing an emergency back-up plan with the client. It should include short-term and long-term needs and may address circumstances such as temporary replacements for personal care attendants and how to respond to power outages that affect equipment.

Examples of content include:

- Whom to call in the event of equipment failure.
- What to do if power goes out.
- What to do in the event of a natural disaster.

The emergency back-up plan is provided in the welcome packet, and the case manager will assist the client to fill it out. One copy will be maintained in electronic form with NEKCOA while a hard copy will remain with the client for reference during an emergency.

h) Develop client-centered care plans/shared care plans

The case manager proactively works with the client to develop a care plan/shared care plan. Self-management is an individual's role in managing the effects, physical and social consequences and lifestyle changes inherent in living with a chronic condition or a functional limitation. Care plans/shared care plans are based on instructions or materials provided to individuals or their caregivers and contain activities that help individuals manage a condition.

The case manager works with the client to identify and confirm specific areas where the client will have responsibility for their care or plan. The case manager may want to begin with simple, achievable tasks as a client gains knowledge, strength and confidence. The Care plan/Shared Care Plan plan is documented in the appropriate

electronic system, and the case manager routinely validates progress and may revise the self-management activities based on changing needs of the client. Self-management opportunities may include:

- Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
- Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).
- Using adaptive equipment (e.g., wheelchair, walker, cane).
- Ability to monitor their condition.
- Reporting an exacerbation of a condition or change in caregiver availability that requires a change in services.
- Money management.
- Paperwork (e.g., annual assessments, financial redetermination, utility assistance, food benefits, transportation).
- Engaging in community resources.
    - The care plan/shared care plan is driven by the preferences and priorities of the client. The case manager documents the shared care plan in the case record and communicates the plan to the member or caregiver verbally and documents the date that it was communicated in the record.

i) Referrals to resources

The case manager may identify opportunities to refer a client to other resources, including mental health supports, supports around addiction, transportation, LTSS resources, primary care services, home delivered meals, housing support, volunteer/Senior Companion, SHIP, etc. The case manager should explain the rationale for the proposed referral to the client and validate that they are interested in the referral. The case manager then provides the information regarding the referral to the client, assists in helping the client access the resource and verifies that the client accessed the referral.

The case manager documents the information in the appropriate electronic system including dates of the conversations, the referral information and final status of the referral.

The case manager follows up after the scheduled referral to identify if services were accessed or if not, what barriers prevented the client from accessing the referral or what preferences may have caused the change. The case manager documents the follow-up in the case record.

j) Receipt of services

The case manager confirms and documents that the client is receiving the services that were planned and documented in the care plan. The case manager validates routinely that services are still being provided and assesses whether any changes need to be made, including if a client prefers a change in services or providers of services.

The case manager may assess and document the following:

- Does the frequency of services need to be adjusted
- Is the provider of services providing quality levels of support
- Does the client have issues or barriers with the services
- If the services are appropriate and appreciated by the client is there a way to thank or recognize the service provider
- Would it be appropriate to discontinue the services – ie. goals are met

If service adjustments or changes are needed the case manager helps in supporting those changes.

All information is documented in the electronic workflow system.

k) Assessing progress

The case manager conducts follow-up with the client at least every 30 days and assesses individual progress to overcoming barriers to care and to meeting treatment goals. The case manager documents the progress assessment timeframe for each goal. During the progress assessment the case manager may revise or close a goal or establish a new goal in collaboration with the client as their priorities and needs change.

Within the program scope of work, care plan goals and objectives are implemented by the case management interdisciplinary team along with vendors, referred service providers, the client and family/caregiver and other identified services staff.

The case manager monitors progress toward care plan goals and updates or modifies the plan according to progress on goals, client and caregiver requests. The case manager communicates with the client or client's advocate prior to any major changes affecting the care plan, including case closure.

l) Care plan review

The care plans are reviewed routinely with NEKCOA supervisors and teams, in case conferences to provide updates and gain insight into assistance and strategies for clients. In addition, the case manager will routinely communicate with clients and families/caregivers regarding the content and status of care plans. The case manager may also use the information in care plans to inform PCPs and clinical care teams.

**C&S 1A Policy: Consumer Rights and responsibilities**

**Purpose:**

NEKCOA will maintain a process through which the organization informs participants of their rights and responsibilities while enrolled in case and support services. This policy and procedure describe the content of the rights information and the process for distribution with individuals.

**Policy:**

NEKCOA will provide individuals with information related to their rights and responsibilities in an easily understandable format. All rights and responsibilities are clearly explained, and

abbreviations and acronyms are defined. The NEKCOA process for communicating the rights and responsibilities of participants will ensure compliance with regulatory requirements. NEKCOA may distribute this information to individuals by mail, fax, email or in person. NEKCOA will mail or provide the information in person to individuals who do not have fax, email, or internet access.

**Procedure:**

1. NEKCOA will provide every participant with a copy of their rights and responsibilities at the initial appointment. The form will be provided either in-person by the case manager, or via mail when in-person delivery is not possible. It is the responsibility of the case manager to ensure that the participant has received, and understands, the material. All case management staff will be educated regarding participant rights and responsibilities during their initial onboarding training.

2. The following is the content of the rights and responsibilities information:

**You have the following Rights as a participant:**

- You have the right to make your own life choices and be supported by NEKCOA to collaborate on decisions with your case manager.
- You have the right to decline participation or disenroll from programs and services offered by NEKCOA.
- You have the right to be treated with dignity and respect. Clients will not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or sexual orientation.
- You have the right to have personally identifiable data and medical information kept confidential; know what entities have access to your information; know procedures used by the NEKCOA to ensure security, privacy and confidentiality. Employees of NEK COA will protect the confidentiality of clients served consistent with the need to protect at-risk individuals and its mandatory reporting status of abuse, neglect and exploitation.
- You have the right to receive confidential and personalized assistance to help you achieve and maintain a life of independence, meaning, and dignity. Within this, you have the right to participate in the development of a care plan to address your needs and receive understandable information.
- You have the right to request a written list of available services, even if the service is not covered. You have the right to discuss options with your case manager. If privately paying, there may be applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding.
- You have the right to choose a service provider from the list furnished by the Northeast Kingdom Council on Aging where multiple service providers are available. You have the right to access information about the provider (including programs and services provided on behalf of the purchaser organization), its staff and staff qualifications and its contractual relationships.
- You have the right to be informed of any change in service(s).
- You have the right to communicate complaints and receive instructions on how to use the complaint process, including the organization's standards of timeliness for responding to and resolving issues of quality and complaints.
- You have the right to know your case manager and know how to request a change in case manager.
- You have the right to receive assistance with navigating appeals regarding services and benefits.
- You have the right to seek services elsewhere if you are not satisfied with the services of the Northeast Kingdom Council on Aging, its provider(s), or both.

**You have the following Responsibilities as a participant:**

- To act courteously and respectfully
- To provide NEKCOA with up-to-date, accurate, and complete information necessary to deliver services
- To follow the mutually agreed-on case management plan or to notify the case manager if you are unable to follow the plan
- To notify the NEKCOA and your usual care provider if you disenroll from the program
- To communicate with your care manager about any problems or concerns that may arise
- To report health care fraud or wrongdoing to NEKCOA, and/or the Special Investigation Unit at 802-241-9210 or going to

  **https://dvha.vermont.gov/providers/special-investigations-unit**

3. All clients new to NEK COA are given the "Clients Rights and Responsibilities" statement and complaint information form. This form details the steps one would take to make a complaint/grievance with the contact information.

If at any time a client voices dissatisfaction with assistance or available services rendered, the employee shall attempt to reach a satisfactory resolution with the client. If this is not possible, please see the contact information below for the Directors of Care & Support Services.

Lucy LeMay
Director of Care & Support Services, North
802-334-4811
Newport, Vermont

Kimberly Emery
Director of Care & Support Services, South
802-751-0418
St. Johnsbury, Vermont

No services will be denied due to a complaint or concern being voiced. The Director of Care and Support Services shall respond to a concern or complaint within ten working days to attempt a resolution. If a client is still dissatisfied, or if the issue is not resolved, the client or the Director of Care & Support Services may contact the Executive Director of NEK COA and expect a response within ten working days.

Meg Burmeister
Executive Director
802-473-4999

If a successful resolution cannot be reached, the client may request a formal review from the Department of Disabilities, Aging and Independent Living or the NEK COA Board of Directors.
The Department of Disabilities, Aging and Independent Living oversees some of the programs administered by NEK COA and these programs may be governed by independent grievance policies. Anyone who is not satisfied with a policy or decision made by NEK COA may contact:

State of Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living
Adult Services Division
280 State Drive, HC2 South
Waterbury, VT 05671-2070

## C&S Policy 1B: Critical Incident Management

**Purpose:**

The purpose of this policy is to ensure NEKCOA effectively responds to critical incidents through the appropriate use of resources. The effective management of critical incidents can assist in minimizing the negative impact of an unexpected event.

**Policy:**

Critical incidents are events or occurrences that cause harm to an individual or LTSS provider, or that indicate risk (e.g., abuse, neglect, exploitation) to an individual or LTSS provider's health or welfare.

Any person who becomes aware of a critical incident is responsible for reporting the incident. Before reporting an incident, measures must be taken immediately to safeguard the participant/employee. This may include calling 911, contacting Adult Protective Services (APS), contacting Child Protective Services (CPS), law enforcement, fire department or other authorities as appropriate.

Examples of critical incidents include, but are not limited to:

- Abuse, including physical, emotional/verbal, or sexual
- Neglect, including self-neglect, or abandonment
- Exploitation, including financial, coercion, or fraud
- Suicide attempts or threats
- Serious threat of violence to another
- Serious injury
- Any situation that *could* result in injury or potential liability such as environmental safety hazards or carelessness
- Thefts or property damage identified in the course of workplace duties.
- Employee actions that jeopardize safety.

**Procedure:**

1. Definition of a critical incident

Critical incidents are events or occurrences that cause harm to an individual or LTSS provider, or that indicate risk (e.g., abuse, neglect, exploitation) to an individual or LTSS provider's health or welfare.

Examples of critical incidents include, but are not limited to:

- Abuse, including physical, emotional/verbal, or sexual
- Neglect, including self-neglect, or abandonment
- Exploitation, including financial, coercion, or fraud
- Suicide attempts or threats
- Serious threat of violence to another
- Serious injury
- Any situation that *could* result in injury or potential liability such as environmental safety hazards or carelessness
- Thefts or property damage identified in the course of workplace duties.

2. Identifying responsibility for critical incident reporting and investigation

a. If a case manager or any case management staff identify a potential critical incident they must document the incident in their notes and inform supervisor.

Depending on the type of incident these will also be reported to:

- **Adult Protective Services (APS):** any incident involving abuse, neglect, exploitation including financial, coercion or fraud within 48 hours
- N**KHS Crisis Hotline**: any suicide attempts, threats at the time of incident.
- **Police/911**: any serious threat of violence to another, serious injury or medical emergency of the client, thefts or property damage at the time of incident.

b. Events listed above are required by law to be reported according to State and Federal Regulations. Case manager report to supervisor and the above entities.

c. The supervisor will review the QIR within 3 business days of receipt to determine the need for further investigation or follow-up. If investigation or follow-up is needed, the supervisor, Leadership team, and case manager will determine the appropriate next steps. The case manager is responsible for appropriate follow-up and communication including with all involved parties. This process ensures that the appropriate processes are followed and that the investigation and resolution is documented.

3. Tracking critical incidents

a. The case manager and supervisor are responsible for tracking all critical incidents using the Peerplace system and codes (Incident report Active, Incident report resolved). All data and information is entered real-time when the information is collected and the issue is investigated and resolved.

b. The supervisor will pull reports for all QIRs quarterly and monitor for trends and prevalence of serious adverse events. Identification of patterns and trends determines what is needed to avoid future occurrences.

Possible remediation may include:

a. An evaluation of staff skills and competencies
b. Training and coaching
c. Creation of new systems or tools
d. Timeline for monitoring and measurement; sustainability plan

c. The supervisor will develop a quarterly report on all QIR's submitted. The report will be presented to the Executive Director and strategies for managing risk, preventing errors, and improving quality will be identified as appropriate.

4. Investigating critical incidents

a. The supervisor will conduct an initial screening of the QIR within 3 business days of receipt for the type, urgency, and severity and then triage for next steps. This supervisor is responsible for oversight of the critical incident investigation in relation to any agency action required. Any investigation from other entities are documented in client's file by the case manager.

b. If no further action is needed the supervisor/case manager documents screening notes in the client file, including rationale for no action needed and closes QIR by using the Incident report resolved code.

c. Staff are contacted by the investigating entity to gather further information and/or documentation needed to make proper determination of next steps.

d. The supervisor is responsible for determining if external reporting and external agency involvement is required. The case manager is responsible for informing external agencies of any details and contact info needed.

e. If warranted, a full investigation and/or Root Cause Analysis (RCA) will be led by the State of VT Quality Department. Interviews will be conducted of all parties involved (directly or indirectly), including any outside agency (e.g. adult protective services, child protective services, law enforcement) as needed.

5. Implementing intervention

a. Care managers must take immediate action to protect the participant from harm and respond to emergency needs by calling the appropriate authorities.

b. Interventions that are implemented may include:

- Reporting and actions by external authorities
- Re-assignment of providers to individuals
- Resolution of the issue
- Re-assignment of staff to individuals
- Training of staff
- Adjustment to processes and establishment of new policies and procedures to ensure safety

c. Any employee who has observed, has knowledge of, or suspects, that any participant is experiencing active suicidal ideation or is in imminent danger will immediately contact the NKHS crisis hotline.

d. Any employee who has observed, has immediate knowledge of, or suspects that abuse or neglect of a minor, older or vulnerable adult has taken place in connection to their professional role is required to report it to the case manager who is responsible for communication with the appropriate authority.

e. Care managers must continue to monitor the progress of participants' unresolved critical incidents, until all risks to the participant's health, safety, and welfare are mitigated. It is not required that the outcome of a report be obtained from CPS, APS, or law enforcement.

f. Anyone who violates NEKCOA Critical Incidents Policy: and/or procedures shall be subject to disciplinary action, up to and including immediate termination, and civil and criminal liability, according to the severity of the infraction.

g. After- Hour Coverage - the Northeast Kingdom Council on Aging's (NEKCOA) normal office hours are Monday through Friday 8:00 am to 4:00 pm. Clients, family members, community partners, and others seeking services may leave a message on the agency's voice message system at any time. The after-hours message states to call 9-1- 1 in case of emergency and states the normal hours of operation.

| Reference # | Policy: Title | | |
|---|---|---|---|
| Policy C&S #2 | Demographic Data Collection | | |
| **Scope** (Optional – Program or Population) | **Department** (Optional) | | |
| **Approval** 8.1.25 | **Original Approval Date** **8.1.25** | **Last Revision Date** | **Next Revision Date** |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA provides comprehensive, patient-centered case management services to participants. The assessment process is used to evaluate the needs and priorities of each participant and develop a plan that is determined by the participants needs and characteristics and their personal priorities. A key step in understanding needs is to systematically collect and use demographic data on both individuals and populations. In addition, it is important to have processes in place to protect the demographic data that is collected. The purpose of this Policy: is to describe the systematic processes for collecting and using individual demographic data and the processes for managing access to and use of the data.

**Policy:**

NEKCOA collects, analyzes, stores and protects population and individual demographic data for use in assessing the needs of populations and individuals enrolled in programs. All data collection and use is conducted in accordance with client, accreditor and regulatory requirements and in compliance with NEKCOA's data confidentiality, management and protection policies and procedures.

This policy describes the specific processes and procedures used in demographic data collection, use and management.

**Procedure:**

1. NEKCOA uses a direct data collection process for collecting race/ethnicity and language data. NEKCOA uses the NCQA definition of direct data collection which is asking individuals for information through enrollment or registration forms, person-specific surveys, data collection scripts or customer service calls, case management forms and health assessments.
2. NEKCOA systematically collects this information on each participant in the population that is eligible and enrolled in case management services.

Information on race/ethnicity and language are collected during the following processes:

- The state may collect the information as part of their screening and referral process and provide that to the agency during the referral process.

- The NEKCOA case intake process includes requesting information on race/ethnicity and language during the referral and enrollment process.

- If unable to collect the information during the referral or enrollment process, the case manager is responsible for collecting that information during the case assessment process.

3. If race/ethnicity and language information are requested but not provided the I&R notes the need for follow-up in the assessment next steps and re-requests the information at the next contact. If the participant refuses to provide the information, the I&R, OC or case manager notes the participants request to decline the information.
4. The data may be provided by state during identification and referral to NEKCOA. NEKCOA collects this information over the phone during outreach and case management calls. NEKCOA documents the responses and information in participant specific case demographic information in the relevant care management workflow system.
5. If a participant is unable to understand or answer the questions the case manager may obtain the information from a HIPAA approved caregiver or family member who can assist the participant and with the participant's permission.
6. NEKCOA collects race/ethnicity data and information using the Office of Management and Budget (OMB) race/ethnicity categories. NEKCOA preferred approach is the OMB a two-question format, asking for ethnicity before race, however there may be circumstances where the OMB combined format is used. In both cases, participants are instructed to select one or more categories that may apply.

   OMB combined format (check all that apply), the questions are asked of the following categories
   a. American Indian or Alaska Native
   b. Asian
   c. Black or African American
   d. Hispanic or Latino
   e. Native Hawaiian or Other Pacific Islander
   f. White
   g. Other, please specify:
   h. (Declined)
7. NEKCOA uses as many channels as available to collect race/ ethnicity; however, asking all individuals to self-identify race/ethnicity may not provide 100% of the needed information. In cases where the NEKCOA is unable to obtain the information we report as declined to answer.
8. NEKCOA directly collects language data on the participants eligible and the enrolled in the case management Choices for Care Program. NEKCOA then identifies the threshold languages for the purpose of translating materials and recruiting staff who speak threshold languages. NEKCOA uses the following to identify language needs in the care management assessment process.
   - The case manager asks "what is your preferred language" and then documents it in the care management workflow system. Participants respond well to this question either answering directly or with the assistance of a caregiver or family member.
   - NEKCOA may use language needs information obtained directly from individuals to enable communication in the requested language (e.g., written information in a language other than English).

| Reference # | Policy: Title | | |
|---|---|---|---|
| C&S 3 | Privacy Protections for Data | | |
| **Scope**<br><br>(All Programs | **Department**<br>(Optional) | | |
| **Approval**<br>8.1.25 | **Original Approval Date** | **Last Revision Date** | **Next Revision Date** |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA provides protection of all healthcare data including information on race/ethnicity and language. This Policy: and procedure describe the processes and requirements.

**Policy:**

NEKCOA maintains processes to protect the privacy of participants through policies related to protected health information (PHI), informational technology security (ITS) and Health Insurance Portability and Accountability Act (HIPAA). This Policy: and associated processes also include management of information related to race/ethnicity and language in addition to PHI. All references to processes and protection of PHI extend to information on race/ethnicity and language.

All data and information is subject to privacy and protection requirements in relevant NEKCOA data and information and technology policies.

**Procedure:**

1. NEKCOA procedures to protect PHI and race/ethnicity and language information include the following:

    a. The case management team informs participants of the organization's privacy practices with the Rights and Responsibilities form for which each client signs off that they have been given a copy. These practices follow state and agency standards and may be adjusted to individual agency contract requirements.
    b. Only the minimal necessary information is shared when performing case management operations.
    c. Timetables are set for retention of PHI. Participant's consent to the disclosure of PHI on the Authorization for Release of Information must be signed every year.
    d. NEKCOA maintains process for returning or destroying PHI no longer needed for business purposes. The policies regarding the destruction of PHI may be adjusted per individual contract requirements.
    e. Participants can request amendments to PHI. Any requests of the participant's information cannot be approved without participant's written consent.
    f. Participants can request an accounting of disclosures of PHI.
    g. The participant has the right to authorize or deny the release of PHI beyond use for case management.
    h. All NEKCOA staff are trained during orientation and annually on NEKCOA data and information privacy protections.
    i. All staff are required to manage data and information in accordance with NEKCOA policies.

2. The NEKCOA maintains internal protection of oral, written and electronic information across the organization. NEKCOA has a process for managing physical and electronic access to PHI and race/ethnicity and language information, including:

a. Protections for physical access management include:

- All NEKCOA buildings are locked with access only allowed by staff with codes or keys.
- All healthcare data and PHI is maintained in locked cabinets if the information is on paper
- All documents on desks and faxes relating to PHI are removed and locked before the end of the day
- Staff who may travel or visit participants are trained to remove all PHI information and to secure it in locked cabinets.
- Any staff leaving the organization are required to return keys and any electronic access systems are disabled for that individual.

b. Protections for electronic access include:

- All electronic systems require unique individual password entry
- Passwords must be unique to each individual and meet strong password requirements in accordance with DAIL policies.
- All systems have automatic time outs which limit exposure of PHI
- Passwords are changed routinely in accordance with NEKCOA policies.
- Passwords are changed when compromised or when staff are directed to change passwords by IT
- Staff are instructed not to write passwords down in a visible manner and to memorize them
- Passwords are automatically disabled for staff who leave the organization

c. Media and devices are managed by IT staff and are subject to policies on maintaining privacy. This includes, but is not limited to:

- Diskettes, CDs, tapes and mobile applications.
- Portable drives.
- Laptops.
- Secure portals.

d. Electronic systems and information transfers are protected by:
- Spam protection
- Phishing alerts
- Identification and disabling attempts at hacking or unauthorized access to systems

3. NEKCOA has defined permissible uses of PHI and language and race/ethnicity data to include:
    a. Direct communications with the participant
    b. Communications with caregivers and others authorized by the participant to receive PHI. Authorization must be in writing.
    c. Identification of participants for addressing health disparities or needs
    d. Summarizing for population analysis and needs analysis
    e. Identification of participants for outreach for program enrollment
    f. Using language data to inform practitioners and service providers of specific language needs
    g. Development of culturally appropriate materials
    h. Assisting in referrals to providers, programs and other services that a participant expresses interest in accessing
    i. Other uses may be appropriate and staff are encouraged to contact management about any issues related to sharing data. Defining and identifying impermissible uses or disclosures of PHI.

4. NEKCOA has defined impermissible uses of PHI and language and race/ethnicity data to include:

    a. Release to unauthorized external individual or organization that is not a business associate
    b. Release to individuals or organizations that the participant has requested there be no access or sharing
    c. Use of data and information beyond minimally necessary use for business operations

| Reference # | Policy: Title | | |
|---|---|---|---|
| 3A | Staffing Needs and Requirements | | |
| **Scope** (Optional – Program or Population) | **Department** (Optional) | | |
| **Approval** | **Original Approval Date** | **Last Revision Date** | **Next Revision Date** |
| 8.1.25 | | | |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA ensures that case management staffing levels and licensure requirements support appropriate program expertise and service levels and meet regulatory standards and guidelines.

**Policy:**

It is the policy of NEKCOA to define staffing needs and licensure requirements and use those requirements to evaluate staffing and guide hiring practices. This Policy: and procedure defines the categories of staff required to support case management, which roles require licensure and the levels of staffing required.

**Procedure:**

1. NEKCOA establishes case management program staffing needs by:

    a. Defining the categories of staff needed and selecting qualified staff to perform each role.
    b. Maintaining staffing levels as required by contract or regulation or through enrollment and service level estimates in order to maintain resource levels and meet program requirements.

2. NEKCOA analyzes data for the case management and general population and uses this information to determine the types of staff roles needed and the requirements and responsibilities of those roles.

The roles required for CFC case management of this population include:

a. Care/Case Manager –Case management is a professional service that assists older adults and adults with disabilities to access the services they need to remain as independent as possible in accordance with their identified goals. Case management is a collaborative, person-centered process of assessment, identifying goals, planning and coordination of services, advocacy, options education and ongoing monitoring to meet a person's comprehensive needs, promoting quality and cost-effective outcomes.

Attachment A includes the job description.

b. Director of Care and Support Services–The Director of Care & Support Services ensures quality, client-focused services by supporting staff in the development of skills needed to provide these services. The Care and Support Department includes I&R Staff, Options Counselors and Case Managers. In addition, this position supports overall agency goals through participation in management-level activities.

Attachment B proivides job description.

c. Executive Director –The Executive Director shall be responsible for overall operation, management and administration of the Northeast Kingdom Council on Aging (NEK COA); will serve as its principal spokesperson; and will guide its progress in fulfilling requirements set forth under the Older Americans Act and the Council's Annual Area Plan for serving the elders and other qualified population in the Council's geographical area of responsibility.

Attachment C includes the job description.

3. Staff roles and responsibilities and licensure requirements

NEKCOA documents staff roles and responsibilities through clear job descriptions that reflect contract requirements and/or regulations. These roles currently do not require licensure. All job descriptions are reviewed by the Board members and Executive Director to ensure clarity, completeness, and fairness. NEK annually reviews staffing requirements and needs and will update the policy if licensure becomes required.

4. Staffing levels

Staffing levels in the case management program are based on the enrollment levels, case levels and the complexity of the population. The table below provides a summary of staffing levels for the case management program within the Care and Support Department

| Role | Description | Ratio |
|---|---|---|
| Supervisor/Lead | Manages team and workloads | 1 FTE: 10 case managers |
| Case Manager | Individual case managers | 1 CM: 50-60 cases/participants |
| Executive Director | Manages overall operation, and administration of the Northeast Kingdom Council on Aging | ED: directly supervises 17 employees |
| Options Counselor | Short term hcbs assessment and review of options | 2FTE agency wide |
| Helpline staff | Responds to helpline calls and walk in appts | 2FTE agency wide |
| Transitions Coordinator | Assists clients transitioning from one setting to another in support of Case Management | 1 FTE |

| Reference # | Policy Title | | |
|---|---|---|---|
| 3B | LTSS Providers Requirements and Resources | | |
| **Scope** (Optional – Program or Population) | **Department** (Optional) | | |
| **Approval** 8.1.25 | **Original Approval Date** | **Last Revision Date** | **Next Revision Date** |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA ensures safe and supportive services to participants by referring to long-term support services (LTSS) providers are qualified, screened and supported in their role.

**Policy:**

LTSS providers are paid and unpaid people and organizations that provide long-term services and supports. NEKCOA verifies the statuses of all employees and entities or persons who conduct business on behalf of NEKCOA. Verification is conducted in accordance with credentials, competencies, professional standing, and federal exclusionary lists in order to maintain compliance with regulatory and industry standards. This policy describes the processes for defining qualifications, conducting screening and background checks and providing support and assistance to LTSS providers.

**Procedure:**

1. LTSS provider qualifications

NEKCOA follows the established state qualifications for LTSS providers (paid caregivers and organizations that provide long-term services and support). These qualifications include but are not limited to the type and amount of experience and/or the type and amount of education the paid LTSS provider must have before providing services. In addition, in order to promote individual safety in the home, the NEKCOA follows state rules and regulations for the qualifications for providers of self-directed services as well as paid LTSS providers.

The qualifications include the following:

c. Disqualifying offenses from a background check (as needed for Home health agency requirements, or per the consumer/surrogate employer discretion).
d. Certifications (as needed for Home health agency requirements, or per the consumer/surrogate employer discretion).
e. Education history (as needed for Home health agency requirements, or per the consumer/surrogate employer discretion).
f. Job history (as needed for Home health agency requirements, or per the consumer/surrogate employer discretion).
g. Relevant experience (as needed for Home health agency requirements, or per the consumer/surrogate employer discretion).
h. Relevant training (as needed for Home health agency requirements, or per the consumer/surrogate employer discretion).

When using Home Health agencies: Those agencies follow the state rules and regulations, and their own criteria in regards to background checks, education, job history, experience, and handles training of their employees.

For consumer/surrogate employers: Employers are certified by the case manager to be able to perform as an employer who completes the ARIS employee packets which include the background checks, but the employers are also responsible for interviewing, obtaining job history, experience, references, and trains their employees as well as completing the timesheets and monitoring job performance.

2. Required background checks

All NEKCOA staff undergo a background check at the time of hire. This is documented by the Executive Director/Fiscal Coordinator in each employee's personnel file. Background checks are also required for all paid LTSS providers (see above). VT Medicaid requires statewide background checks for criminal history, abuse and neglect for paid LTSS providers, before they can begin work.

The hiring agency, or consumer/surrogate employer (through ARIS) conducts background checks and uses information from the following sources to complete the background checks.

Prior to establishing employment or a business relationship, the State of VT (and /or DAIL) determines contractors, consultants, vendors, joint venture parties, and affiliates providing ancillary medically related services or products which can be accessed using the current List of Excluded Individuals and Entities (LEIE) of the OIG, the General Services Administration (GSA) System for Award Management (SAM) exclusion list, and the Medicaid Suspended and Ineligible Provider List. The results of the screening, and any updates, provided to the AAA agencies.

The types of paid LTSS providers subject to this screening include:

- Home Health agencies
- Consumer/Surrogate Directed employers

3. Additional screening of LTSS providers.

The hiring agencies/entities are responsible for:

- Reference checks.
- Interviews.
- Signed statements about job history.
- Alcohol/drug screening.
- Credit checks (as needed by agencies)

4. Assistance to LTSS providers.

NEKCOA understands the value of LTSS providers and works collaboratively with them. A key focus is to provide support services and information that address safety, resource adequacy and assistance in their role and environment.

a. All LTSS providers have access to necessary supports and resources to enable them to appropriately and safely complete assigned tasks including:

- Training through V4A.
- Waiver meetings/community partners meetings.
- Care Team coordination.

b. Have access to emergency services for their safety and protection:

- LTSS provider agency/consumer/surrogate directed employees must follow their own established protocols for safety and report any issues or concerns to the case manager.

- Case manager works with the client and team to address the concerns and make changes as needed to address the concerns/issues.

c. All LTSS providers are provided information on how to file a grievance which includes:

- All clients new to NEK COA are given the "Clients Rights and Responsibilities" form. This form details the steps one would take to make a complaint/grievance with the contact information.
- If at any time a client voices dissatisfaction with assistance or available services rendered, the employee shall attempt to reach a satisfactory resolution with the client. If this is not possible, please see the contact information below for the Directors of Care & Support Services.

Lucy Lemay
Director of Care & Support, North
802-334-4811
Newport, VT

Kimbery Emery
Director of Care & Support, South
802-751-0418
St. Johnsbury, VT

- No services will be denied due to a complaint or concern being voiced. The Director of Care and Support Services shall respond to a concern or complaint within ten working days to attempt a resolution. If a client is still dissatisfied, or if the issue is not resolved, the client or the Director of Care & Support Services may contact the Executive Director of NEK COA and expect a response within ten working days.

Meg Burmeister
Executive Director
802-473-4999

- If a successful resolution cannot be reached, the client may request a formal review from the Department of Disabilities, Aging and Independent Living or the NEK COA Board of Directors.
- The Department of Disabilities, Aging and Independent Living oversees some of the programs administered by NEK COA and these programs may be governed by independent grievance policies. Anyone who is not satisfied with a policy or decision made by NEK COA may contact:

State of Vermont Agency of Human Services

Department of Disabilities, Aging and Independent Living

Adult Services Division

280 State Drive, HC2 South

Waterbury, VT 05671-2070

| Reference # | Policy Title | | |
|---|---|---|---|
| 3C | LTSS Staff interactions | | |
| **Scope** (Optional – Program or Population) | **Department** (Optional) | | |
| **Approval** 8.1.25 | **Original Approval Date** | **Last Revision Date** | **Next Revision Date** |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA ensures appropriate clinical involvement in case management and provides referral processes that support (LTSS) providers. These processes include reinforcement of the role of the primary care and treating provider teams in meeting the clinical needs of participants.

**Policy:**

Case management and support of LTSS participants requires assessing and understanding of the participants' needs and then coordinating with a broad set of clinical and non-clinical services to address those needs. There are instances in the assessment, care planning and monitoring process where it is appropriate to involve a licensed clinical professional or notify and/or refer the participant to a clinical professional. This policy and procedure describes the circumstances where a licensed clinical professional is required and the processes for involving or referring to a licensed clinical professional. The Policy: was developed with the input of a licensed clinical professional and is reviewed and updated by a licensed clinical professional.

**Procedure:**

1. Clinician involvement and referrals.

During any phase of the case management process (assessment, planning, monitoring) the care manager/case manager or care navigator may have an interaction with a participant that requires involvement of, consultation with, or referral to a clinician. A clinician is a professional who is licensed to provide medical and behavioral healthcare to individuals, and it may be an NEKCOA team member or part of the participants care team. If a case manager has any questions or needs involving determining whether to involve a clinician, they should immediately contact their supervisor.

The following situations and situations similar to this require referral to and involvement of a clinical professional.

- The participant is responsive to questions but is highly disoriented and there is no caregiver present to confirm that this is a normal state – conference in the participants primary care physician (PCP) or medical social worker and/or LTCCC (State RN).
- The participant has lost their medications or appears to not understand their medications at all or why or how to take them and does not have a caregiver who is assigned to give their meds-conference with the PCP/medical social worker or mental health professional as designated by the consumer.
- The participant is highly agitated or appears to have significant mental health issues or concerns - conference with the mental health crisis line, the participants PCP/medical social worker, or eldercare clinician as applicable.

- The participant is not conscious or responsive – call 911
- The participant is interested in social services but does not fully understand them – through person centered approach develop a relationship with consumer and support system (family, neighbors, friends, medical/mental health providers) to explain and develop a plan of support.
- The participant is experiencing acute significant medical symptoms, changes in their medical condition, or confusion about instructions given to them by their provider – refer to the PCP/ medical social worker and/or emergency services.
- The participant has fallen and has no caregiver present – use PERS if applicable or call 911.
- Any situation where the case manager feels that assistance is needed or they have concerns, contact the PCP/medical social worker, service providers, family to develop a care coordination conference and make a Shared Decision plan.

When referring to another service, the case manager or team member ensures that they make contact with the referral and either stay on the line or confirm the arrival of the referred party. Document all observations and interactions in the data system and reflected in the Shared Decision plan.

2. Interactions appropriate for non-clinical staff.

Nonclinical care management/case management staff who have completed the required NEKCOA training are authorized to communicate with participants by phone or in person in order to complete the following activities – case assessment, case planning and case monitoring. As part of this scope of work they can also interact with caregivers, family members, the participant's primary care provider and LTSS service providers. At no time, can the nonclinical staff diagnose or provide medical or clinical advice or input to a participant.

Any significant change in the participant's medical or behavioral health status must be reported to the participant's PCP office. All questions related to interpreting or clarifying medical or behavioral information provided by the participant should be discussed with the client, and the team.

The following interactions, communications and situations require nonclinical staff to contact the individual's practitioner.

- Significant changes in medical or behavioral health status – case managers and non-clinical staff must notify the NEKCOA supervisor. The case manager then contacts the practitioner based on the recommendation from the Supervisor.
- Emergency room or hospitalization admissions – when the case manager becomes aware of an emergency room or hospitalization event, they must contact the PCP/hospital to coordinate care planning and provide the details. The case manager may involve the NEKCOA supervisor in this interaction.
- Questions or clarification of medications – if there are questions or concerns about medications the non-clinical staff or the case manager must contact PCP.
- Requests to speak to or see the practitioner – All participants are encouraged to see or communicate with their PCP as needed. The nonclinical case manager may assist in arranging a virtual or in-person appointment upon request by the participant or their caregiver.

All referrals to coordination and communication with practitioners are dated and documented in the case management workflow system.

3. Situations requiring referral to clinicians

Clinicians are individuals who are licensed to provide medical or behavioral healthcare and social services to participants. The state RNs assist in designing the LTSS case management program and may advise or assist on specific cases.

In addition, the participants may have clinical professionals or practitioners who provide them with direct care and this can include physicians, nurse practitioners and licensed behavioral health professionals. These practitioners form the care team for the participant and are responsible for diagnosing, treating and managing the participant's conditions. They appreciate proactive communication and involvement since they are responsible for the participants' health and well-being and are an important resource for the participant and knowledgeable about their conditions.

There will be instances where it is necessary or advisable to refer the situation, question or concern to the participants practitioner care team. These instances are described in Steps 1 and 2 of this policy and procedure. If a case manager has any question that they feel requires clinical input, they are encouraged to refer the situation or question immediately to a clinical professional or their supervisor for assistance.

4. Usual care provider information requests

There may be instances when an external party or usual care provider requests information about the participant who is in care management. Usually care providers include LTSS providers, primary care practitioners or specialists responsible for individuals' care.

It is important that NEKCOA and our teams protect the confidentiality and privacy of our members when coordinating requests for information. The following is the process for responding to requests from external parties.

- If the person requesting the information is a usual care provider and they are requesting nonclinical information (eg. confirming an upcoming appointment or asking if a prescription was filled)
- If the person requesting is not a usual care provider or the caregiver or family the case manager must notify their supervisor of the request. The supervisor will then follow the state privacy policy and work with the consumer to explore Release of Information (ROI).
- If the person requesting the information is a usual care provider and they are requesting clinical information the request must be forwarded to the NEKCOA case manager to review with the consumer if not authorized on the ROI.

All requests and resulting actions are documented in the case management workflow system.

| Reference # | Policy Title | | |
|---|---|---|---|
| C&S 4 | Case Management Assessment | | |
| **Scope** (Optional – Program or Population) | **Department** (Optional) | | |
| **Approval** | **Original Approval Date** | **Last Revision Date** | **Next Revision Date** |
| 8.1.25 | | | |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA provides comprehensive, person-centered Choices for Care case management services to clients. A key step in care planning is to conduct an initial screening of the client's needs and a comprehensive assessments that provide information on the clinical, functional, psychosocial, social needs and physical needs of the client. The information from this assessment process is then used to develop the care plan and involve the appropriate services and supports.

**Policy:**

NEKCOA conducts assessments that address health, functioning and communication preferences of the clients. The assessment process also includes an evaluation of current resources and resource needs to identify gaps or adjustments that are required.

This policy describes the specific processes and procedures used in the case management assessment process, including how the assessments are documented and the process for confirming the completion of the assessment.

**Procedure:**

1. Choices for Care Case management clients can be identified through a variety of sources including direct referrals, provider referrals, and outreach campaigns. The NEKCOA supervisor receives referrals and confirms a client's eligibility for Choices for Care case management and interest. The client is informed that enrollment in the Choices for Care case management program is voluntary.
2. Once a client is enrolled in Choices for Care case management the assessment process is initiated. The assessment process is intended to be person-centered and gather information about their health status, social concerns, behavioral health needs and preferences. The assessment is used to then create goals and a care plan.

3. The Case Manager is expected to complete the assessment and create a plan within 30 days of receiving the clinical eligibility. Assessments are then conducted when there is a significant change in the client's health or if they have been hospitalized with significant changes. The new assessment is also documented in the records systems.

4. The assessment can take place over the phone or in person based on initial conversation and mutually agreed upon timeframe.

5. The assessment includes collection of information on the following health, functioning and communication preferences:

   a. Assessment of the client's health status

      The Case Manager evaluates the client's health status by interviewing the client and/or caregiver as well as evaluating any medical or clinical information that is provided and available. This evaluation includes identifying key diagnoses and conditions that the client has and determines if the condition is part of their health history or is a current condition. The Case Manager conducts the assessment and dates and documents the results in the appropriate electronic system.

      In addition to obtaining a comprehensive list of diagnoses and conditions the assessment includes:

   - Screening for the presence or absence of physical conditions and their current status and documenting when the condition first occurred and ended (if acute). This should include both medical and behavioral concerns.
   - Evaluating and documenting how the individual perceives and self-reports their health status.
   - Current medications lists include current schedules and dosages.

   b. Documentation of Clinical History, Including Medications

      The Case Manager documents the client's clinical history based on interviews, data collection or review of claims or clinical data that is available. The clinical history is documented in the appropriate system and includes a description of the situation, the date or estimated date when the illness, condition or service occurred, and whether it is resolved or ongoing. The documentation includes (where relevant to the client and the information is available):

   - Past hospitalizations, emergency room visits, inpatient and outpatient surgeries and major diagnostic and treatment procedures, including description of relevant medical issues and estimated date.
   - Any medications the client is taking.
   - Significant past illnesses and treatment history including a description of illnesses, symptoms, treatments of conditions and the estimated dates when the situation occurred and whether the condition is ongoing and/or a current concern.
   - Relevant past medications including estimate date when initiated.
   - The clinical history also includes client's health care providers names and types.

c. Activities of Daily Living (ADLs)

   The Case Manager assesses the client's needs in terms of activities of daily living (ADL) to include an evaluation of the individual's ability to complete the task on their own, use supports such as assistive technology or equipment or need human or service assistance to complete. The categories of ADLs that are assessed includes:

   - Grooming.
   - Dressing.
   - Bathing.
   - Toileting.
   - Eating.
   - Transferring (e.g., getting in and out of chairs).
   - Continence.
   - Walking/Mobility.
   - Bed Mobility

d. Instrumental Activities of Daily Living (IADLs)

The Case Manager assesses functional status related to instrumental activities of daily living (IADLs), such as housekeeping, money management and ability to navigate transportation. The Care Manager documents any roles that caregivers, family, or other support services play in addressing IADLs. Supports include both assistive technology and human assistance needed to complete a certain activity.

This may include evaluation of IADLs to include:

- Managing finances
- Shopping
- Laundry
- Preparing meals
- Managing medications
- Housework and basic home maintenance
- Handling transportation (driving or navigating public transit)
- Using the telephone, internet and other communication devices
- Adaptive equipment management

e. Special Needs, Supplies, Preferences

The Case Manager conducts the assessment and documents the results in the appropriate electronic records system, noting any special needs, supplies, or preferences that the client may have such as specialized wound care dressings, ramps, walkers. The Case Manager also documents whether they have adequate support or supplies and/or need assistance obtaining the needed supplies.

f. Behavioral Health Status

The Case Manager conducts an assessment of the client's level of depression using the ILA and if client identifies areas of concern with depression or anxiety a referral is made to the appropriate entity for further assistance and assessment.

- Mental health conditions – current status of mental health as well as prior diagnoses, treatment or resolution of concerns.
- Substance use disorders – misuse or treatment for drug, alcohol, or other substance concerns.
- The assessment also collects information on providers who have, or are currently treating the client for concerns and can serve as a referral flag for identifying emerging needs.

g. Cognitive Functioning

The Case Manager assesses and documents the client's level of cognitive functioning including:

- The individual's ability to communicate and understand instructions.
- The client's ability to understand their medical condition and
- The ability to process information.

- The caregiver or a family client may be assisting the client with understanding and completing tasks, but the evaluation focuses on the client by assessing factors such as:
  - Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
  - Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
  - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
  - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
  - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

h. Social Needs

Social needs are economic and social conditions that affect a wide range of health, functioning, overall well-being and quality-of-life outcomes and risks. The Case Manager evaluates and documents at least three or more factors that impact the client's life, functioning and ability to meet goals. The Case Manager uses the assessment, interviews the client and caregivers, and documents in the appropriate electronic system, the presence of social needs such as:

- Current housing and housing security.
- Income sources and levels such as social security or other income sources.
- Transportation and limits to ability to access services and care.
- Access to local food markets.
- Social connection – isolation, loneliness or lack of social supports (also assessed as part of social functioning)

i. Social Functioning

Social functioning refers to an ability to interact easily and successfully with other people. The Case Manager conducts the assessment and gathers information on the client's ability to interact socially and identifies concerns that may affect an individual's mental and physical health.

The assessment includes evaluating factors such as:

- Interaction and engagement with friends and family
- Relationships to neighbors
- Involvement with church or other social groups
- Ability to use technology to remain connected to friends and family
- Social connection – structural, functional and quality of how individuals connect with others including assessment of social isolation, loneliness and/or inadequate social supports
- Employment status

j. Health Beliefs and Behaviors

Health beliefs and behaviors may reflect cultural and social beliefs about health problems, perceived benefits of action and barriers to action. The Case Manager conducts an assessment of health beliefs and behaviors (e.g., optimism, self-efficacy, nutrition habits, physical activity and alcohol and tobacco use) that could improve or impede an individual's ability to adhere to the case management plan.

The assessment includes evaluation and documentation of factors such as:

- Optimism
- Beliefs and concerns about healthcare including resistance to certain types of treatment that could result in barriers or consideration of options
- Self-efficacy
- Physical activity
- Smoking
- Alcohol use
- Medication adherence
- Beliefs and concerns about the condition or services the individual is receiving
- Accessibility to services

k. Cultural and Linguistic Needs

The Case Manager conducts an assessment of the client's culture and language requirements, to identify potential needs or barriers to effective communication or care and acceptability of specific treatments. The Case Manager documents the client's preferred language and health literacy and how well they understand their healthcare needs.

The assessment includes consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs and includes consideration of factors such as:

- Health care treatments or procedures discouraged or forbidden by religious or spiritual beliefs
- Preferences related to cultural and language background such as treatment by a same sex provider
- Involvement of church and cultural community in health planning and support
- Important religious and cultural celebrations and traditions
- Family traditions related to decision-making, illness, death and dying
- Health literacy assessment

l. Visual and Hearing Needs

The Case Manager assesses and documents vision and hearing needs of the client. This information is used to determine if the client's needs are currently met or if additional services or tools are needed. The evaluation includes assessing:

- Visual impairment and need for, or use of, visual aids (e.g., talking clocks, large-font prescription labels), or reading assistance such as glasses, including partial or complete blindness.
- Hearing impairment and need for, or use of, hearing aids or other supports or devices (e.g., sign language interpreters).

m. Risk in Physical Environment

The Case Manager assesses physical environment risks and other safety concerns to include the risk of falls, risk of misuse of medication, accessibility of exits, safety and emergency services. The assessment is conducted in the appropriate electronic system and can include an evaluation of rugs or loose cords that might contribute to falling, items on high shelves or locations.

6. The assessment process also includes evaluation and collection and documentation on the following areas of resource needs:

    a) Assessment of caregiver resources

    The Case Manager interviews the client and any caregiver or family clients to evaluate the adequacy of paid and unpaid caregiver resources (e.g., family involvement in the case management plan and in carrying out the plan). The Case Manager evaluates and assesses availability (how much time the caregiver is available), and caregiver capacity (abilities, interests) to provide support. The assessment also considers and evaluates undue burden on the caregiver (e.g., unreasonable stress or strain) and caregiver support needs (e.g., training, respite).

    The Case Manager also assesses whether a client may need caregiver resources in the future and under what circumstances.
    The Case Manager documents the results in the appropriate electronic information system:
    - Whether the individual is independent and does not need caregiver assistance.
    - Number of caregivers, and current assistance provided.
    - Caregiver needs for training or other supportive services.
    - Caregiver contact information and preferences.

    b) Assessment of available benefits

    The Case Manager assesses the adequacy of health benefits and available resources to support and fulfill the care plan. This evaluation includes both services the client is receiving or is potentially qualified to receive:

    - Health insurance benefits
    - Social security programs
    - Special coverage program benefits
    - Palliative or specialized care programs
    - Benefits covered by the organization and by providers
    - Services carved out by the state
    - Fuel assistance
    - Services that supplement those the organization is contracted to provide, such as:
    - Community mental health
    - Senior and subsidized housing
    - Renter’s Rebate, Homestead Declaration assistance

    c) Assessment of community resources

    The Case Manager assesses and documents both community resources that the client is already receiving or that they could qualify to receive. This includes assessing eligibility for supplemental community resources (e.g.,

organizations, facilities, services) that can address social needs or other needs or barriers identified in the assessment. The assessment includes a determination of eligibility for supplemental community resources.

This includes consideration of services such as:

- Community mental health through NKHS Front Porch, Adult Outpatient, ElderCare Clinician
- Vocational programs through HireAbility/Voc Rehab.
- Meals on Wheels/2-1-1 Food Pantries, Farmer's market coupons, Farm to Family, Commodities , CSFP, Veggie VanGo
- Volunteer and Senior companion services.
- Government aid (e.g., food stamps, housing assistance, fuel assistance) Telephone/internet discount, electric discount programs.
- Senior centers/congregate meal sites
- Adult day care.
- Support groups.
- Poverty outreach groups.
- Housing resources.
- Legal aid.
- Lifeline (PERS)
- Tax assistance

7. NEKCOA is dedicated to person-centered planning, and it is critical to gain the client's input, priorities and core needs are addressed. The assessment process and documentation ensures that care planning is person-centered and includes the following:

a) Assessment of service needs

The Case Manager assesses what services the client is receiving and what services are needed. The documentation includes frequency and contact information for current services if able to provide. These are documented in the appropriate electronic system, and may include:

- Primary/specialty care providers
- Durable medical equipment
- Health monitoring devices
- Modifications to the home/Assistive devices
- Transportation services
- Meal delivery
- Financial aid
- Housing assistance
- Home health/PT/OT, Speech Therapy/ Palliative care/Hospice care

b) Assessment of person-centered prioritized goals

Based on the assessment activities and in working with the client, the Case Manager develops a set of person-centered prioritized goals that are important to the client and are intended to result in a desired outcome. The goals

are documented in the care plan and are prioritized as Low, Medium, or High. These goals become the core of person-centered care planning and address a desired outcome. The Case Manager uses these goals to develop a person-centered case management plan.

- Goals must be SMART, which means:
- Specific – avoid broad goals, and make sure they are related to a health or social need
- Measurable – set a measurement or benchmark for the goal to assess progress objectively
- Achievable – goals must be written so that success is realistically possible for the client
- Realistic – goals do not have to be easy, but they should not be so difficult that they cannot be achieved through the reasonable efforts
- Time-bound – tied to being measurable, there should be a time element to the goal to keep the client on track in progressing toward their goals

- Examples of person-centered prioritized goals include:
    - Client's priority is to obtain housing near friends
    - Client would like to find a stable income
    - A key priority for the client is to maintain Medicaid eligibility
    - Client would like to complete a GED program
    - Receive authorization/referral for durable medical equipment
    - Obtaining and taking prescribed medication
    - Volunteering
    - Client would like to spend more time with family
    - Being able to move independently and walk on their own
    - Keeping my diabetes or other conditions well managed
    - Social goals
    - Engaging in faith-based practices
    - Regularly meeting with doctor and other specialists
    - Obtaining transportation to doctor appointments

c) Assessment of preferences

The Care Manager identifies and documents the client's preferences for lifestyle, living situation and how care is to be provided. These preferences are then incorporated into the care plan and how case management and LTSS services are delivered. Preferences may include:

- Where to live
- Preferred care givers and service providers
- With whom to live
- When to go to bed
- When and what to eat
- Whom to involve in care planning
- Which services and service providers to use as available
- When/how often to bathe
- Condition of home

d) Assessment of life-planning activities

The Case Manager discusses life-planning activities and preferences. The Case Manager assesses whether the client has completed life-planning activities such as wills, living wills or advance directives and health care powers of attorney and Medical or Clinician Orders for Life-Sustaining Treatment forms, guardianship, Rep Payee. These documents may designate the people permitted to make decisions on behalf of the individual, obtain information about the individual's health status and services received, or be notified about transitions in care.

If life planning activities are determined to be appropriate, the Case Manager documents what activities the individual has performed and what documents are in place. If life-planning activities are determined not to be appropriate, the Case Manager documents the reason in the appropriate electronic system. A designated representative can make decisions on behalf of individuals who are incapacitated and cannot communicate life-planning preferences. A client may not be interested in life-planning initially and the Case Manager may elect to continue to check in on their interest and offer to help.

The Case Manager provides information regarding where to fill out an advanced directive to clients who indicate that they are interested.

This may include:

- Providing life-planning information (e.g., brochure, pamphlet) to all individuals in case management
- Helping plan for caregiver transition in the event of death or illness that would prevent the caregiver from assisting the individual

e) Assessment of preferred communication methods

The Case Manager identifies and documents how the client prefers to receive information from the Case Manager. This may include phone calls, email, or mailed materials and certain days or times of the day when the client prefers to be contacted.

8. The assessment findings are summarized either in the care plan or the notes and provide a summary of the client's clinical and social situation and their preferences and priorities.

| Reference # | Policy Title | | |
|---|---|---|---|
| C&S 5 | Transitions of Care | | |
| **Scope** | **Department**<br>Click here to enter text. | | |
| **Approval** | **Original Approval Date** | **Last Revision Date** | **Next Revision Date** |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA monitors care transition events in order to support participants as they move from one care setting to another, such as to or from independent home living, acute care, emergency department, skilled nursing facility, custodial nursing facility, or rehabilitation facility. NEKCOA coordinates needed services for participants enrolled in case management programs. These services are provided on both a short-term and long-term basis and include supporting participants as they move from one level of care and independence to another. The focus is to keep individuals independent in their own homes if that is what they prefer while addressing needs that may emerge and require other levels of care or service. NEKCOA provides care transition processes that support continuity of care, service and information.

**Policy:**

Care transitions are when participants move between care settings (e.g., from home to hospital) as their condition and care needs change during the course of a chronic or acute illness. Participants who are experiencing transitions are particularly vulnerable to receiving fragmented and unsafe care if transitions are poorly coordinated. NEKCOA transitions coordinator and case management services serve a key role in ensuring that information, care and services are coordinated and participants and caregivers are kept supported and informed. Transitions may be planned or unplanned. Planned transitions include elective surgery or a decision to enter a long-term care facility. Unplanned transitions include sudden hospitalization or the use of the emergency from resulting from emergencies and urgent needs.

Transitions span any care setting that involves a provider or place that delivers health care and health-related services, and includes:

- Acute care facilities.
- Emergency departments.
- Skilled nursing facilities.
- Custodial nursing facilities.
- Rehabilitation facilities.
- The home and community.

The receiving setting is the setting responsible for care after a transition and the case management program and care managers are responsible for coordinating across the entire continuum and span of the transition. Additionally, we have a transition coordinator to ensure that clients receive the support needed for transitions.

NEKCOA maintains a process to monitor and identify client care needs and/or problems that may contribute to unplanned transitions and provides community-based assistance when transitions occur. This policy describes the specific processes and procedures used to support safe transitions of care.

**Procedure:**

9. Identify individuals who transition

NEKCOA has developed processes to support proactive identification of participants who are experiencing both planning and unplanned transitions between settings. Due to the sudden nature of some transitions and the need for prompt response we have developed a care transition coordinator position which allows for ease of connection between facilities and our agency. The care transition coordinator communicates with the case manager and collaboratively tracks these transitions, evaluating how the transition will impact the services provided by NEKCOA and supporting the needs of the participant in collaboration with the referring and receiving settings and teams. NEKCOA focuses on transitions that impact the participants inability to live independently at home including transitions to hospital or skilled care.

NEKCOA uses the following approaches to identify participants who are transitioning (Team Based care teams in both hospital service areas which include home health agencies, mental health agencies and community action agencies coordinate care. Both hospitals utilize patient ping which is an electronic alert system that informs ER visits and admissions/discharges to the hospitals. We have developed an OCHA agreement with one hospital service area and are developing one with our other hospital service area to increase the ability to stay informed of admissions/discharges in real time thus allowing for better coordinated transitions. We have also implemented a transitions coordinator role to help facilitate accurate referrals and a more balanced transition process.

- Routine checking using the Patient Ping tool from Bamboo Health. This tool provides notifications and history around ED, hospital and SNF use. (we are on automatic notifications)
- Notification by servicing providers such as in-home care that the participant is needing a different level of care.
- Check-in by the case manager includes evaluation of whether a participant is at risk of or needing another level of care. The case manager maintains communication with both the client and care coordinator at said facility to ensure transitions are responsive to the client's needs. Frequency is dependent on the client's situation.
- Monthly care team reviews with supervisors are able to identify individual participants at risk of health status or environmental changes leading to transition and draw upon assessment information gathered from routine monthly phone contact, quarterly, and annual face-to-face reassessments.
- Periodic review of rates of all participant admissions to facilities and ED visits through our ACO work. This is monitored through team-based care team meetings and is reported at semi-annually in order to identify areas for improvement.

The case manager documents in the care management system when a transition is planned or has occurred and dates and descriptions of the situation and the follow-up.

10. Provider notification

The case manager may become aware of a transition either directly by initiating the transition or through notification by other parties, or directly from a hospital or caregiver. The case manager or transition coordinator notes the date they were notified of a transition and then communicates with usual care providers within 2 business days. Usual care providers include LTSS providers, primary care practitioners or specialists responsible for individuals' care. If the case manager is unable to reach the usual providers by phone, email, or text they conduct outreach 2 more times on 2 separate business days in order to attempt to reach the providers. The case manager documents the date, content and results of all provider notification and outreach. Based on the information related to the transition, the case manager updates the care plan to reflect on the transition within 3 business days including noting any needs that have been identified and that impact the case management plan. If the participant does not have a PCP the case manager establishes a goal to work with the participant to obtain a relevant PCP (geriatrician, family practice).

This process is followed for all transitions both admissions and discharges to different levels of care.

9. Case management support during transition

   Each participant is assigned a designated case manager. The case manager works directly with the participant and their caregiver and family support in conducting the assessment, creating the care plan and monitoring progress. The case manager is also responsible for helping coordinate and support the participant through care transitions. Once notified or aware of a transition the case manager has 2 business days to contact the participant or their assigned representative (eg. caregiver, family) and provide their name and contact information and let them know they are responsible to supporting them through the transition. The case manager should encourage participants and representatives to contact them with any questions or concerns. The case manager also provides updates on the transition to the participant or their representative on timely basis in order to keep them informed.

10. Communication and documentation of key information

NEKCOA recognizes that a key and important role of the case management process is to facilitate the sharing of necessary information across settings and professionals and caregivers involved with each of the settings – referring and receiving.

When the case manager receives notification of the transition they are responsible for conveying vital information to the receiving setting in order to ensure the delivery of safe and adequate care. The case manager:

- Contacts the receiving setting within 2 business days of notification to share information such as: the individual's health status and goals, medical conditions, functional considerations, medications and services that the participant had been receiving.
- Provides the receiving organization a copy of the care plan if requested and provides information on caregivers and other support services the participant was receiving.
- Provides their contact information and requests that the receiving organization notify the case manager as discharge planning is initiated or if a new transition is planned for the participant.
- The case manager contacts the receiving setting for a status report on the participant as needed.
- Documents and dates all communications and outreach in the care management workflow system.

11. Communicate about the care transition process

The case manager is responsible for communicating with the participant and their designated representative about transitions.

- If the case manager is notified of a planned and future transition the case manager contacts the participant in 1 business day to confirm the participant's understanding of the transition, explain what their role will be and how they will support the participant. During that conversation the case manager also confirms the role the participant would like their designated representative to have during the transition. The case manager documents the dates and content of the conversation in the care management workflow system.
- If the transition is unplanned, the case manager conducts outreach to the participant within 2 business days. The case manager outreaches to the receiving organization within 2 business days. The case manager involves the designated representative as previously approved by the participant or gains approval from the participant to contact the designated representative. The case manager documents the dates and content of the conversation in the care management workflow system.

12. Transition tracking status

    The case manager is responsible for tracking and documenting the status of the participant's transition. This information is key to planning for the participants return to the core services provided by the NEKCOA

and other programs. It is also useful in planning updates to the original care plan and arranging for new or revised
services.
The case manager checks on the participant's transition status as needed and documents the date of the outreach and information that is received. The information that is documented can include:

- The current location of the participant.
- The planned date of transfer or discharge to another location.
- The anticipated receiving setting.
- Contact information for those coordinating care at the current setting.
- Service needs that are anticipated after discharge or transfer.

7. Coordination and collaboration with the discharge team

The case manager remains in contact and conducts follow-up with the transition receiving setting in order to evaluate and plan for the participant's transition back to their home or alternative setting Once discharge planning is initiated in the receiving setting, the case manager will actively support providing information to the discharge team and will collaborate on planning for the participant's return to the home.

The case manager is responsible for:

- Identifying the discharge planning team contact(s) and noting names, titles and phone numbers in the participant record in the case management system.
- Documenting the date and nature of all communications to include email, text, phone and virtual meetings.
- Maintaining meeting notes and summaries within the participant case record.
- Noting all follow-up items, dates for those items and whether completed.

The case manager provides information to the discharge planning team and receives information including:

a. Original care plan information.
b. Description of the home environment and considerations that relate to the discharge needs such as stairs or access concerns.
c. Details about informal support available to the individual.
d. Resources and supports the LTSS case management organization can provide to the individual upon their return to the community.
e. Significant changes in the participant's medical psycho-social or functional status.
f. Updated discharge plan reflecting the roles and responsibilities of both the discharging setting and the LTSS case management organization.

The case manager uses information from the discharge planning team to update the care plan and prepare for the participant transitioning back to home.

8. Reassess and revise the case management plan

The case manager conducts a reassessment of the participant's needs as part of the transition back to the home setting. The case manager uses this reassessment to review the original care plan and, with the participant's involvement and input, revise the care plan accordingly. This assessment should include reviewing and updating the goals, barriers and self-management activities as appropriate. The case manager completes this reassessment within 14 business days of the participant returning home or the alternative setting.

As part of this process the case manager also completes the following:

a. Communicate changes to the case management plan

The case manager discusses the proposed and agreed upon care plan and service changes with the participants and their representatives within 14 business days of when they return home. The case manager also communicates and coordinates changes with service providers.

b. Review and document medications and changes

Transitions in care may result in changes or adjustments to medications. The case manager reviews and documents the new medications and compares the list to the prior medications. If there are differences in the prior and new medications, the case manager communicates with the participant's PCP and/or treating provider to confirm the changes. The case manager also confirms that the participant or the caregiver understand the new medications. If the participant has questions with the new or any medications the case manager helps coordinate communication with the PCP or treating provider to explain the changes

9. Case management reporting and information analysis

NEKCOA monitors individuals' information (e.g., self-reported, case manager reports, claims data) and identifies individuals who are at risk of experiencing an unplanned transition. NEKCOA reviews data from the following sources to identify participants at risk for unplanned transitions or complications.

- In-home assessment – Case specific
- Case manager documentation - Monthly
- LTSS provider reports – Monthly
- Reports from family/friends/caregivers- Case specific
- Information reported by the individual- Case specific

10. Actions related to risk reduction

The case manager may identify through their assessment and care planning or through reports that a participant is at risk for transition or complications and they initiate and document actions taken such as:

- Arrange for meal delivery to improve nutritional status.
- Work with the individual and arrange for home modifications to reduce fall risk (e.g., increase physical therapy, reduce clutter, tape down loose rugs, eliminate long electrical cords, install grab bars in the bathroom).
- Arrange for a PCP visit or home visit to assess the participants status.
- Provide educational materials on how to manage chronic conditions such as diabetes.
- Arrange for companion service or adult day program to reduce social isolation.
- Develop a triggering criteria to identify individuals whose condition might trigger an intervention that can be part of supervision.
- Provide Care coordination to identified at-risk individuals.

11. Annual analysis

NEKCOA conducts an annual analysis to evaluate rates of unplanned admissions to facilities and emergency room visits, in order to identify areas for improvement. The analysis includes quantitative and qualitative analysis and results in an action plan. Through our accountable care community work NEKCOA management review these transitions.

| **Reference #** 6 | **Policy: Title**<br>Care and Support Department Management Staff Training | | |
|---|---|---|---|
| **Scope**<br>(Optional – Program or Population) | **Department**<br>C&S management | | |
| **Approval**<br>8.1.2025 | **Original Approval Date** | **Last Revision Date** | **Next Revision Date** |
| **References/Evidence Base** CMS, NCQA, (State Regulations) | | | |

**Purpose:**

NEKCOA ensures case management staff receive initial and ongoing training that supports provision of comprehensive and quality case management and care management services to all AGENCY program participants. These processes include confidentiality and privacy training as well as skills and program processes.

**Policy:**

Comprehensive initial and ongoing training is crucial to ensuring case management team members are informed and supported in their work providing care and case management to participants. This Policy: and procedure describes the subjects, scope and focus of the training that is provided. The training may include NEKCOA developed materials as well as training provided by other programs, NEKCOA and regulators.

**Procedure:**

1. Initial Orientation and Training Approach

All new case and care management team members undergo orientation and initial training. The Executive Assistant is responsible for scheduling the onboarding sessions, which includes IT/equipment allocations, access to databases, and general orientation to the organization. Program-specific orientations are conducted after the general onboarding sessions, and are coordinated by the program directors. When all orientation is completed, the supervisor confirms via a signed checklist that the training has been completed.

2. Training Materials and Methods

The initial training is delivered using the following materials:

- In-person or live virtual training with agenda, calendar, and access to shared file documents to review. New staff meets with program directors within the first few days to learn what each program provides and how to make referrals.
- Additional materials and tools available on the shared network drive for the individual programs.
- Recordings of current trainings are provided along with materials from the trainings.
- Shadowing done with staff members to show the process, procedure, method

3. Initial Training Scope

A general orientation and initial training occur within the first two weeks of the new hire's start date, while additional training and evaluation takes over the first 90 days for all new hires on the case management team and includes the following learning components and modules.

A. General Orientation Topics

a. NEKCOA Business, Communications, and Social Media policy Overview

Trains staff on the history and mission of the NEKCOA how the organization communicates with outside entities, and how staff are expected to communicate about their work, including the organization's social media policy.

b. Quality Overview

Staff are provided with a general overview of the commitment to quality and quality assurance programs and how to report quality incidents.

c. Policies and Procedures

The orientation includes an overview of NEKCOA policies and procedures.

d. Disaster Management Overview

New hires are instructed on the NEKCOA emergency communication process and system that is used in selected situations to manage the needs of staff and participants.

e. Client Programs and Services

In order to understand the various resources available within NEKCOA, staff are introduced to the programs and services that are made available to clients.

f. Adult Mandated Reporting Training

The orientation includes training on mandated reporting situations and processes.

B. Care Management Program Training

a. Confidentiality and Privacy

The NEKCOA training program includes training on privacy and confidentiality that is consistent with HIPAA rules and regulations. The training is a mandatory course and is delivered via an online course accessed through the NEKCOA website. NEKCOA employees are required to re-take this course once every year.

b. Emergency Situations and Critical Incidents

NEKCOA recognizes that there may be instances where the participant, the caregiver and/or the case manager experience an emergency or a critical incident occurs. The focus of the training is on recognizing when these situations are occurring and then knowing what processes to follow in order to ensure safety and appropriate interventions.

The training includes how to identify scenarios, how to react and report situations, and how to document both the incident as well as the intervention, referral or resolution. The scenarios and training include identifying, reporting and managing suspected abuse and neglect as well as other critical incidents.

**c.** Program operations and evidence training

NEKCOA training is designed to provide staff with comprehensive information on the program operations and processes and the sources and standards that are used to guide the design of the case management program.

The training curriculum includes providing information on the sources of evidence and professional standards used to operate the program. These include:

- Care and Support standards developed from VT Dept of Health Care Services and Medicaid plans, and CMS rules and regulations
- Resources such as the V4A, and VT Disabilities Aging and Independent Living
- Evidence based tools used to screen for behavioral health needs, falling and safety risks and other assessments
- Self-management support – how to develop a self-management plan with the participant and update the plan and provide materials.
- Referral process – how to refer participants to health plan and community-based resources
- Critical incident and mandatory internal and external reporting requirements.

d. Behavioral change models

NEKCOA trains and orients new case management team members on behavioral change models. These models encourage understanding of individuals' beliefs about the causes of disease or disability and available treatments, and whether conditions or risks can be managed. Behavior change models can foster collaboration with an individual to develop a case management plan including self-management aspects of the plan. Behavior changes and readiness to change principles are key to person-centered care planning.

NEKCOA provides training on Motivational Interviewing techniques, including using Camden cards, Relationship mapping, open ended questions, summarizing, and using affirmations and reflection as techniques to assist with behavior change.

e. Goal setting

NEKCOA is committed to person-centered care and case managers are trained to use the assessment and care planning process to establish specific, measurable and time-targeted objectives that address what is most important to an individual. These goals should relate to the participant's medical, social and behavioral needs and priorities and are central to developing a case management plan that focuses on their priorities and readiness to change. The goals are person centered and structured as SMART goals.

Each goal is documented and assigned a priority of (high, medium, or low). The case manager then describes the participants' preferences, the interventions and actions that are planned. The case manager

uses the notes section to document follow-up on a goal, monitor status and capture additional information on participant preferences.

The case manager may collect information or conduct an assessment that indicates a goal needs to be revised. If the participant has achieved a goal the case manager notes the results and closes the goal.

f. Referral processes

NEKCOA trains case managers in how to identify the need for a referral, where, to whom and how to refer the participants. The process includes following up to validate that the referral was completed and identify whether there were issues that need to be resolved. The referral is documented in the care management workflow system.

Referrals can include:

- Internal resources and programs
- Community based programs and services
- LTSS services
- Transportation, food and housing services
- Health care providers and teams

g. Cultural competency and linguistic appropriateness

NEKCOA provides training on cultural competence, which is the ability to respect and respond to diverse individual values, beliefs, behaviors and needs when providing services. Culturally and linguistically appropriate practices seek to advance health equity, improve the quality of health care and reduce health care disparities by assessing, respecting and responding to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.

Cultural competency is taught through training on working with diverse populations, which includes approaches and basic knowledge for different racial and ethnic groups, as well as population groups including mothers, veterans, older adults, and people with disabilities. The training includes discussion prompts to allow for dialogue that is intended to highlight the unique experiences and knowledge of our staff regarding their own unique cultural knowledge. The training also includes identifying and respecting language preferences including using interpreters when needs. The training addresses the importance of showing attention and respect and patience with participants who speak a different language. Using confirming non-verbal techniques and showing the importance of providing them access to people and providers who speak their language. The training also addresses cultural aspects of certain languages such as using respectful versus demanding terms.

The approach starts with meeting with the participant and during the assessment where the case manager is able to get information on the participant's culture, upbringing, religion and other information that guides what is important to them. The case manager is taught to recognize and respect cultural characteristics and understand how they relate to the participants' life, health care and choices and preferences.

This training includes:

- Communication styles.
- Cultural differences based on individual demographics.
- Disability and aging sensitivity training.
- Identifying health care preferences due to culture or religion such as preferred gender of physicians or nutritional and food choices.
- The role of family in cultures.

h. Reducing bias

Bias describes the positive or negative associations, attitudes, preferences or stereotypes that influence behavior and decisions. Bias may be implicit (unconscious) or explicit (conscious), and requires awareness, acknowledgment and conscious effort to overcome.

NEKCOA provides training to all team members on understanding bias and developing skills to identify and eliminate bias in communications and actions. The training also includes developing strategies for clients who exhibit bias including how to manage inappropriate communications or behaviors.

i. Health literacy

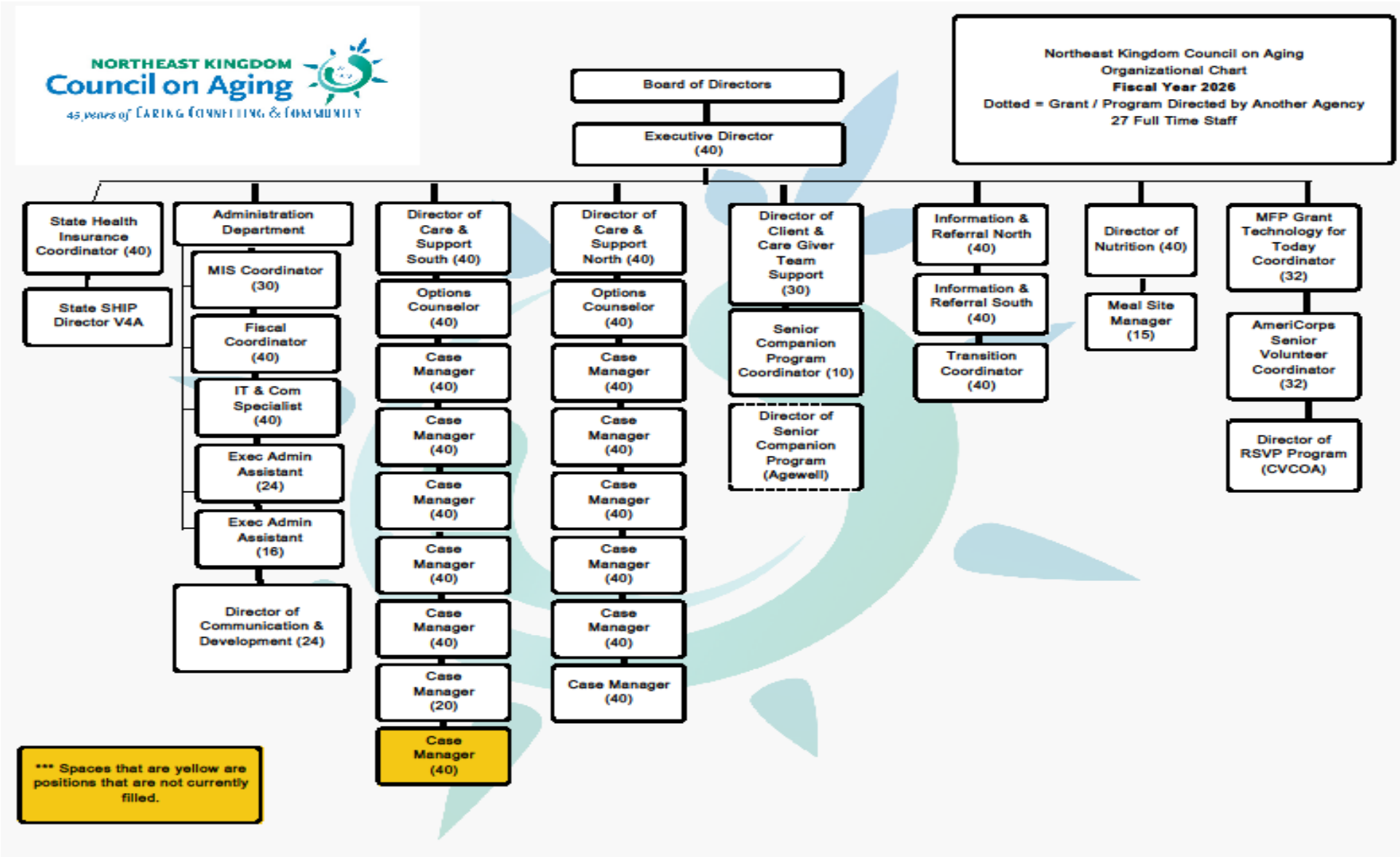
NEKCOA provides training on how to evaluate and understand participant's level of health literacy. Health literacy is an individual's capacity to obtain, communicate, process and understand basic health information and services and to make appropriate health decisions. The case management team is also trained on once understanding the level of health literacy, how to help participants understand information in a manner that is comfortable to them and how to improve their understanding.

This training is provided through health education skills training, which methods and skills for activating participants to achieve their health goals. The training emphasizes the teach-back method and language skills through breakout sessions where staff are encouraged to practice these skills in a safe environment with immediate feedback from both peers and trainers.

The case management team is also taught to confirm a participant's understanding by asking the participant to confirm or teach back the information or process.

4. Training confirmation

Once any training is completed the case manager sends the training title, the duration of the training, and the date it was completed to the Executive Assistant. The Executive Assistant maintains the training records for all employees and sends the record to the case manager, Supervisor, and Executive Director each year to verify and record.


NORTHEAST KINGDOM
Council on Aging
45 years of Caring Connecting & Community
Northeast Kingdom Council on Aging
Organizational Chart
Fiscal Year 2026
Dotted = Grant / Program Directed by Another Agency
27 Full Time Staff
Board of Directors
Executive Director (40)
State Health Insurance Coordinator (40)
State SHIP Director V4A
Administration Department
MIS Coordinator (30)
Fiscal Coordinator (40)
IT & Com Specialist (40)
Exec Admin Assistant (24)
Exec Admin Assistant (16)
Director of Communication & Development (24)
Director of Care & Support South (40)
Options Counselor (40)
Case Manager (40)
Case Manager (40)
Case Manager (40)
Case Manager (40)
Case Manager (40)
Case Manager (20)
Case Manager (40)
Director of Care & Support North (40)
Options Counselor (40)
Case Manager (40)
Case Manager (40)
Case Manager (40)
Case Manager (40)
Case Manager (40)
Case Manager (40)
Director of Client & Care Giver Team Support (30)
Senior Companion Program Coordinator (10)
Director of Senior Companion Program (Agewell)
Information & Referral North (40)
Information & Referral South (40)
Transition Coordinator (40)
Director of Nutrition (40)
Meal Site Manager (15)
MFP Grant Technology for Today Coordinator (32)
AmeriCorps Senior Volunteer Coordinator (32)
Director of RSVP Program (CVCOA)
*** Spaces that are yellow are positions that are not currently filled.

# Advisory Council 2025

Northeast Kingdom Council on Aging

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**NOVEMBER 2024 - OCTOBER 2025**

**NORTHEAST KINGDOM COUNCIL ON AGING - BOARD OF DIRECTORS** rev.4/30/2025

**President** - Ross Farnsworth **Vice President** - Michele Garges

**Secretary** - Nancy Hogue **Treasurer** - Evan Hammond

| Name | Status of 3-yr Term | Role | Address | Phone | Email | Term Start | Term Ends |
|---|---|---|---|---|---|---|---|
| Ross Farnsworth | * | President | 401 Cliff St., St. Johnsbury, VT 05819 | 802-495-8463 | Ross.Farnsworth1986@gmail.com | 2023 | |
| Michele Garges | * | Vice President | 1271 Joe's Brook Rd., Danville, VT 05828 | 912-481-3139 | mchgarges1@gmail.com | 2023 | |
| Evan Hammond | ** | Treasurer | 126 Colby Road, Lunenburg, VT 05906 | 802-892-5277 | gevanhammond@gmail.com | 2020 | 2025 |
| Nancy Hogue | ** | Secretary | PO Box 280, Danville, VT 05828 | 802-535-900 | njh813@mac.com; hoguen@bcbsvt.com | 2020 | 2025 |
| Debby Dorsett | * | | 1425 Hinton Hill Rd, Westmore VT 05860 | 802-558-9166 | debbydorsett@gmail.com | 2023 | |
| Janel Hinrichsen | * | | 42 Main St., PO Box 579, Lyndonville, VT 05851 | 970-529-6888 | janhin@live.com | 2023 | |
| Erin Kelly | * | | 51 Zabarsky Road, St. Johnsbury, VT 05819 | 802-745-8467 | Rmteck3@gmail.com | 2023 | |
| Phyllis Mitchell | * | | 4013 Sheffield Square Rd. Sheffield, VT 05839 | 860-839-2373 | pmmitchell12@hotmail.com | 2025 | |
| Terri Schoolcraft | * | | PO Box 18, 1177 Bayley Hazen Rd. Peacham, VT 058 | 802-498-7851 | terri.schoolcraft@outlook.com | 2025 | |
| Bill White | * | | 148 Slap Hill, Hardwick, VT 05843 | 860-912-2499 | shacker1250@gmail.com | 2025 | |
| Shawn Hallisey | * | | 450 Woodland Rd, Waterford, VT 05819 | 860-405-5827 | shallisey@kingdomkarehc.com | 2025 | |
| Mark Beattie | * | | 3537 Red Village Rd, Lyndonville, VT 05851 | 802-745-7094 | beattiemw@charter.net | 2025 | |
| | (*) First Term | | | | | | |
| | (**) Second 3-yr term | | | | | | |
| **Other** | | | | | | | |
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| John Riley | | Capital Acct Srv | 606 W. Hill Rd, N. Middlesex, VT 05682 | 802-229-5988 | john@capitalaccounting.org | | |

# Northeast Kingdom Council on Aging

- St. Johnsbury Office -
481 Summer Street, Suite 101
St. Johnsbury, VT 05819

-Newport Office-
Derby Times Square, 5452 US RT 5 Suite A
Newport, VT 05855

# EMERGENCY Preparedness and Continuous Operation PLAN

# Table of Contents



This Emergency Response Plan is designed to be used by the Council's Leadership Team and staff who will coordinate services in the event of an emergency.

Emergency and evacuation plans are identified herein for the protection of employees in the event of a fire, bomb threat, earthquake, public health emergency etc. Leadership Team members are to assist during training drills to ensure the personnel in their area have sufficient training to safely evacuate the building and assemble in the designated area.

NEKCOA has and continues to participate in local emergency response planning meetings and that information is utilized to inform this document.

## In An Emergency Situation Always Call 911

- Fire Medical Emergency/Rescue
  - **(Do not attempt to transport another employee or client in a medical emergency)**
- Hostile threatening person
- Theft or other unlawful acts
- Suspicious person or incident observed by an employee
- Toxic fumes -evacuate the area by sounding a verbal warning
- Bomb threat If in doubt call 911Contact leadership team member

Staff are provided with an emergency contact list of all employees provided by the administrative staff to keep current information for each staff member in the event of an emergency situation.

**Leadership Team Responsibilities**

Leadership team includes Executive Director, Director of Care and Support North and South, Director of Nutrition, Director of Caregiving Services, Director of Communications/Development, Volunteer Services Coordinator, Fiscal Coordinator.

Leadership team will:

- Review emergency plan coordinated with staff they supervise.
- Assist with emergencies management.
- Direct occupants during emergencies.
- Maintain emergency call list for utilities and hazardous substances (front desk).
- Maintain organization records contact information is checked and updated quarterly.

**Continuity of Operations:**

As developed from the pandemic response

The leadership team will meet to develop a plan specific to the issue or incident impacting operations.

- ❖ All staff have access to remote work capacity thru use of laptops and phones.
- ❖ Leadership team will conduct a review of needs and challenges specific to the current situation impacting operations.
- ❖ Supervisors will review continuity of operations specific to the employee's role.
- ❖ Supervisory staff will have direct contact with each worker to ensure safety and plan to maintain operations during an emergency situation.
- ❖ Executive Director will be lead contact to DAIL regarding continuity of operations during an emergency situation.

**Personal safety awareness**

In the event that there is a hostile person or situation, call 911 immediately if you are able to do so safely. If you cannot call, try to excuse yourself from the room and give signal to a staff member.

Given that staff also conduct home visits, the need to stay attentive to the environment is paramount.

If an employee anticipates a challenging situation in a scheduled appointment:

1. alert your supervisor and/or co-workers to the details of the situation and
2. have a plan in advance (a check-in call, meeting with a door open, or more than one person in the room, etc.).
3. Conduct a joint visit/meeting with a second staff member

**On site emergency (Newport and St. Johnsbury offices)**

- ➢ **Leave the building in an orderly manner by the nearest exit.**
- ➢ **Avoid crowding. Descend any stairs with special care. DO NOT RUN.**
- ➢ **Do not use the elevator during an emergency of any kind.**
- ➢ **Assist in the evacuation of the physically disabled.**
- ➢ **If conditions permit, computers can be quickly locked by pressing Ctrl-Alt- Delete prior to evacuation.**
- ➢ **If evacuation is due to a fire, the last person out of an area should be sure the door is closed.**
- ➢ **Do not attempt to take belongings other than purses, keys, etc.**
- ➢ **Proceed to emergency designation area**

**Action in the event of an emergency during a home visit:**

- ➢ **Exit the home**
- ➢ **Call 911**
- ➢ **Contact your immediate supervisor or Executive Director**

**EVACUATION PROCEDURES**

***St. Johnsbury office:***

Staff members covering front desk are responsible for having an awareness of staff in building.

**Staff should evacuate to:** *THE CORNER OF SUMMER AND WEBSTER STREET, JUST ON THE OTHER SIDE OF THE FUNERAL HOME.*

**A member of the leadership team will act as lead for coordination with emergency personnel and conveyance of directives set forth by emergency responders.**

***Newport office:***

**Exit office through either staircase (main stairs or set off the kitchen) dependent on the situation occurring.**

**Staff should evacuate to:** *ACROSS THE STREET AT THE NORTH COUNTRY FEDERAL CREDIT UNION.*

**A lead should be designated by staff on site to coordinate with emergency responders. If no leadership staff are on site, then a staff member should contact Director of Care and Support or ED immediately to be informed.**

**VISITORS' POLICY FOR ST. JOHNSBURY AND NEWPORT**

**STAFF-ONLY AREAS AND VISITOR ESCORT POLICY:** All staff areas, including those behind keypad-entry doors, are designated as *escort-only* zones. Visitors must be escorted to and from these areas by the staff members they are here to see. Until their appointment time, visitors should remain in the lobby.

**SEVERE WEATHER:** Employees will be informed of severe weather via phone, in person, **or by** email. Employees would then be encouraged to stay in their current location until the threat subsides. Contact supervisor or leadership team member for guidance.

**Early Dismissals/Closings/Delays:** In these cases, the Executive Director or designee will make the decision regarding weather-related early dismissals, delayed openings or closings. The decision will be based upon a multitude of factors including actual hazardous driving conditions and other travel advisories. Staff will be notified through workday communications or the agency telephone tree calling system.

**MEDIA ANNOUNCEMENTS:** News representatives will be referred to a leadership team member who is responsible for official responses to the press and other news media concerning emergencies in the building. **No one else is authorized to respond to these inquiries.**