

Elder Care Clinician Program Manual

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PURPOSE: The purpose of this manual is to:

- Describe the Elder Care Clinician Program, including history, purpose, eligibility and services,
- Describe the roles and responsibilities of the State of Vermont, Area Agencies on Aging and Designated Mental Health Agencies,
- Describe the way Elder Care Clinician funding is managed, and
- Provide requirements, instructions and technical support to recipients of Elder Care Clinician Funding.

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This manual is maintained by the State Unit on Aging within the Agency of Human Services, Department of Disabilities, Aging & Independent Living (DAIL), Adult Services Division and will be updated annually as needed in collaboration with the Department of Mental Health.

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I. Purpose and History of the Elder Care Clinician Program

The purpose of the Elder Care Clinician (ECC) Program is to provide mental health services to older Vermonters who need mental health supports and are not able to receive services in an office-based setting due to physical, psychological and/or emotional barriers.

With an aging population and a growing prevalence of mental health needs, the ECC program provides critical services to older Vermonters who would otherwise not receive them and risk deterioration of health and institutional care.

In 1999, the Vermont Department of Disabilities, Aging and Independent Living's (DAIL) Successful Aging Task Force identified two key aims: to promote mental health and increase access to mental health services. The Northeast Kingdom Council on Aging took up the challenge and used funds from the Successful Aging Initiative to address a vexing concern: how to better serve the very frail clients who struggled with mental illness. Case managers felt ill-equipped to address the problems related to mental health conditions and substance use they were encountering on an almost daily basis. The agency contracted with two mental health clinicians from the local community mental health center and sent them on home visits with the case managers to see what could be done. Though not all encounters led to successful outcomes, the clinicians were able to identify and offer treatment or facilitate referrals for older Vermonters struggling with anxiety, depression, dementia, adverse drug reactions and substance abuse disorders. Case managers were able to provide much needed social, financial and homemaking support to persons previously reluctant to accept their help.

Advocates for older Vermonters immediately recognized the positive benefits and the potential for expansion. In 2000, the Community of Vermont Elders (COVE) led a successful grassroots effort to obtain a \$250,000 legislative appropriation to extend the outreach mental health program across the state and the Elder Care Clinician Program was born.

In the first full year of operation, 450 Vermonters age 60 and older, almost half of whom had depression, received mental health services for the first time. Since that time, the program has continued to serve between 300 and 500 older adults every year.

II. Partner Roles and Responsibilities

The ECC Program is built upon a foundation of partnerships at the local and state level. All partners have critical roles to play in achieving successful outcomes for participants and sustainability of the program. Currently, partnerships involve the state's five Area Agencies on Aging and seven designated mental health agencies.

1. **Area Agencies on Aging (AAAs).** As the organizations designated in Vermont to develop a comprehensive and coordinated system of services and supports at the local level, AAAs oversee the program at the local level. This includes contracting with the local designated mental health agency for the services, promoting the program with the public and additional partners in the community for referrals, identifying potential individuals for referral, and connecting ECC clients with additional supports and services available through the AAA.
2. **Designated Mental Health Agencies (DAs).** As the organizations designated in Vermont to provide mental health services to Vermonters, DAs are tasked, under their contracts with the AAAs and their Master Grant Agreements with Department of Mental Health (DMH), to hire, train and support staff to provide clinical therapy to older Vermonters in their homes (services outlined in Section IV). DAs are responsible for oversight of staff and reporting to AAAs and DMH. In addition, DAs are responsible for accepting referrals from AAAs and other community sources and determining eligibility based on the criteria in Section III below. ECCs must also attend quarterly meetings coordinated by DAIL.
3. **Department of Disabilities, Aging and Independent Living (DAIL).** DAIL provides state general funds to support the ECC program and oversees that funding, partly distributed through the AAAs to the DAs and partly distributed by MOU to DMH. DAIL supports the ECC work by coordinating and facilitating quarterly meetings attended by DAIL, DMH, ECCs and supervisors, seeking resources and speakers, and advocating for older Vermonters' mental health needs.
4. **Department of Mental Health (DMH).** DAIL and DMH have an intergovernmental agreement for DMH to oversee the Global Commitment funding and Medicaid billing of the ECC services by the DAs. DMH includes requirements for the ECC services in their

Master Grant Agreements with the DAs. DMH also provides program data reports and clinical expertise.

III. Client Eligibility

Eligibility is based upon four key criteria:

1. **Age:** Clients must be age 60 or older. “Collateral Contacts” such as family caregivers may be also be served.
2. **Community Dwelling:** Clients must be living in a community-based setting, not an institution such as a nursing home. In addition to single family homes and senior housing buildings, Assisted Living Facilities, Residential Care Homes and Adult Family Care homes are all considered community-based settings.
3. **Mobility Status:** Clients must be primarily homebound. This means that they have difficulty accessing traditional office-based services due to physical, psychological and/or emotional barriers. This mobility status can and does shift for some clients.
4. **Greatest Need:** When staff resources are limited, priority should be given to those in greatest economic need (based on poverty status), social need (based on disability status, minority status and social isolation) and those with the greatest unmet mental health needs who are unable to meet those needs via other supports. Clients shall not be prioritized based on insurance coverage or individual ability to pay for services. Clients shall not be prioritized based on the agency they work with most closely. Every effort must be made to serve clients in greatest need. *See more in Section V. below on the establishment of waiting lists.*

IV. Allowable Services

All of the following five services are allowable services to be provided to clients served within the Elder Care Clinician Program. Clinical assessment and therapy are priority services; other services may be provided as needed and appropriate.

1. Clinical Assessment
2. Individual and/or Family Therapy
3. Service Planning and Coordination
4. Community Supports
5. Medication Management

The following definitions are outlined in more detail in DMH's [Mental Health Provider Manual](#) (April 2019):

Clinical Assessment services evaluate individual and family strengths, needs, existence and severity of disability and functioning across environments. A clinical assessment is a service related to creating an accurate picture of an individual's needs and strengths. It may take a variety of forms and include multiple components, depending on the age and functioning of the client, and the program the individual is being considered for. An assessment includes a review of relevant information from other sources, such as the family, health care provider, other State agencies or programs, or others involved with the individual and their family.

Individual Therapy is specialized, formal interaction between a mental health professional and a client in which a therapeutic relationship is established to help resolve symptoms, increase function, and facilitate emotional and psychological amelioration of a mental disorder, psychosocial stress, relationship problem/s, and difficulties in coping in the social environment.

Family Therapy is an intervention by a therapist with an individual and/or their family members considered to be a single unit of attention. Typically, the approach focuses on the whole family system of individuals and their interpersonal relationships and communication patterns. This method of treatment seeks to clarify roles and reciprocal obligations and to facilitate more adaptive emotional, psychological and behavioral changes among the family members, and includes couples therapy.

Medication Evaluation, Management and Consultation Services include evaluating the need for medication, prescribing and monitoring medication, and providing medical oversight, support and consultation for an individual's mental health care in coordination with other medical providers. Medication evaluation, management, and consultation services may be done in a group setting with client agreement to participate in this treatment forum. Separate notes must be written for each individual.

Service Planning and Coordination assists individuals and their families in planning, developing, choosing, gaining access to, coordinating and monitoring the provision of needed services and

supports. Services and supports that are planned and coordinated may be formal (provided by the human services system) or informal (available through the strengths and resources of the family or community). Services and supports include discharge planning, advocacy and monitoring the well-being of individuals (and their families) and supporting them to make and assess their own decisions.

Community Supports are individualized and goal-oriented services to assist individuals and their families with clearly documented psychosocial needs and diminished function. Services assist the individual to access community supports and develop social skills necessary to improve overall function and promote community connectedness and positive growth. These services may include support in accessing and effectively using community services and activities, advocacy and collateral contacts to build and sustain healthy personal and family relationships, supportive counseling, and assistance in managing and coping with daily living issues. Accessing and using community services and activities may include the development of those skills that enable an individual to seek out, clarify, and maintain resources, services, and supports for independent living in the community, including communication and socialization skills and techniques. Supportive counseling includes services directed toward the elimination of psychological barriers that impede the development or modification of skills necessary for independent functioning in the community. This activity can be provided either face-to-face, through telemedicine or by phone. Managing and coping with daily living issues may include support in acquiring functional living skills resources and guidance in areas such as budgeting, meal planning, household maintenance, and community mobility skills.

Important Note about Case Management and the Roles of the AAA and DA:

Both AAA staff and DA staff may provide case management services to Elder Care Clinician clients, depending on the agency that client is most connected to. For the purposes of this program, case management is defined as 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. Per the services above provided by Elder Care Clinicians, case management is most similar to "service planning and coordination."

If a AAA is providing regular case management services to a client who is being seen by an ECC, the ECC would not provide case management services, but would refer case management

needs to the AAA. If the client was referred to the ECC by a different agency and is not receiving case management services elsewhere, it would be appropriate for the DA to use case management staff (not the ECC) to support the client in this way as needed. There may also be instances in which an ECC may be in a client's home and may be able to quickly support a client with an immediate issue typically handled by a case manager in order to facilitate the client's ability to then focus on clinical therapy. Good communication between the DA, AAA or any other organizations involved is critical to holistic and person-centered support of the client, regardless of who may be doing the case management at any given time.

Service Innovations

If a DA and/or AAA wishes to explore innovations around service delivery models or partnerships within the ECC program, the DA and/or AAA should reach out to DAIL for approval. DAIL will work with the agency on a demonstration project with outcomes and measures. If deemed successful, the demonstration could be offered in other regions by interested DAs and AAAs.

V. Processes and Procedures: Outreach, Referral, Intake, Service, Documentation, Reporting, Waiting Lists and Billing

1. **Outreach:** Outreach should be conducted in community to reach the targeted client population. Both AAAs and DAs should work cooperatively to promote the ECC services within their designated services areas.
2. **Referral:** Referral processes and protocols may vary from agency to agency. Referrals may come from a variety of sources including but not limited to AAAs, SASH, VNAs, Adult Days, senior centers, primary care offices, hospitals, families and caregivers. Referring organizations should be informed by the AAAs and DAs of the basic eligibility for the services in order to be able to make appropriate referrals.
3. **Intake:** Intake processes may vary from agency to agency, and the ECC intake should follow the process as defined by the agency. Best practice indicates that the fewer staff an older person must speak to prior to seeing the ECC, the more positive their first session with the ECC.

4. **Service:** Only the services outlined above in this manual may be provided. If an ECC seeks to provide additional or alternative services, the DA must consult with the DAIL and DMH lead contacts.
5. **Documentation and Reporting:** ECCs should document services provided in the standard format of the agency for inclusion in the Monthly Service Reports (MSR) submitted by DAs to DMH. ECCs should also document additional data required within the Master Grant Agreement and submit directly to DAIL. This quarterly reporting includes screening data (alcohol, substance use, suicide risk, depression and cognitive impairment) and current waiting list data.
6. **Maintaining Waiting Lists:** With limited ECC capacity and high volumes of referrals, some DAs may experience the need to establish waiting lists. DAs must work to prioritize those in greatest need per the criteria above in Section III.4, track the number of people on the waiting list at any given time, and report waiting lists to DAIL quarterly.
7. **Billing:**
 - a. Medicare: Only psychiatrists, psychologists and Licensed Clinical Social Workers (LICSW) may bill Medicare for mental health services. If a client has Medicare and the clinician has one of these credentials, Medicare must be the primary billing source. Clinicians that are not licensed social workers will also provide services to Medicare recipients in greatest need.
 - b. Medicaid: If a clinician cannot bill Medicare, and the client has Medicaid, the DA must bill Medicaid using the “Elder Care” cost center.
 - c. Private Insurance: If the client has private insurance, the DA will bill accordingly.
 - d. Clients without any insurance coverage: The DA must strive to serve those in greatest need regardless of their ability to pay. The DA may institute a sliding scale option or payment schedule option for clients with some ability to pay.
 - e. The Medicaid Elder Care cost center must be used for clinical therapy and other services provided to the client in the place where the client lives. Office-based services must not be billed to Elder Care. There are occasional exceptions to this rule, for example, in the case of a person with significant hoarding who does not allow anyone inside their home, so the option of meeting at a location comfortable for the client, such as the senior center or adult day center, could be offered. This is rare and should be determined on a case by case basis. In

addition, some service planning and coordination may take place in the office or a psychiatrist may be consulted in the office.

VI. Funding

The Elder Care Clinician Program is funded by a combination of Medicaid, Medicare and commercial insurance revenue, the state general fund appropriation, and local agency funds.

The Flow of Funding:

1. Medicaid Funds:

- a. DAIL has an MOU with DMH for DMH to hold the DAIL Global Commitment Medicaid dollars for ECC so that DAs can bill Medicaid through DMH.
- b. DAs bill Medicare/Medicaid/Other Insurance as allowable.
- c. By the end of the State Fiscal Year, based on Medicaid billing data submitted by DAs, DMH submits a request to DAIL for state general funds to match the Medicaid Global Commitment funds.
- d. DAIL transfers general funds to DMH to match the Medicaid funds.

2. State General Funds:

- a. Since 2000, each year the legislature appropriates general funds to the DAIL budget for ECC services.
- b. DAIL determines the amount of funding for each AAA service area based on the designated intra-state funding formula and shares the funding amounts with AAAs via their annual Resource Projections document. AAAs then contract with DAs for ECC services.
- c. DAIL awards AAAs the balance of their general fund award after the match is subtracted (varies by AAA based on IFF and Medicaid billings).
- d. AAAs pay DAs all or some of general fund balance awarded, depending on the terms of their local contract.

3. Local Agency Funds:

- a. AAAs may include additional funding from other sources in their contract with the DAs to increase services provided.
- b. DAs may use additional funding from other sources to supplement funding received by Medicare, Medicaid, and AAA contracts to increase services provided.

Requirements to Receive State Funding:

For a AAA to receive the annual General Fund Award, the following criteria must be met:

1. A contract must be in place for the current State Fiscal Year between the AAA and DA and a copy sent to DAIL upon execution.
2. The DA must have MSR documentation of providing ECC services to a minimum of 10 clients within the current State Fiscal Year.

If the AAA anticipates that either of these criteria cannot be met, the AAA must reach out to DAIL to explore solutions at least three months prior to the end of the State Fiscal Year. DAIL and DMH will work with AAAs and DAs to find the best solution for a particular service area.

If an ECC leaves a DA in the middle of a contract year, the DA should be given a reasonable timeframe to recruit a replacement clinician (three to six months). However, if a DA is without a clinician for more than six months, the AAA must reach out to DAIL. DAIL and DMH will work with AAAs and DAs to find the best solution to the staffing challenge for a particular service area. This may include support for amending a contract and/or seeking alternatives for providing the service.

Performance Management at the Local Level:

It is the primary responsibility of the AAA to monitor program performance at the local level. DAIL encourages AAAs to include performance measures in contracts with the DAs, including a minimum number of clients to be served and client satisfaction based on annual surveys. Contracts should be clear that funding will be based on meeting specified performance measures.

VII. Communication and Contacts

DAIL maintains a current list of all Elder Care Clinicians across the state and communicates by email regularly with ECCs and their supervisors. ECCs meet together with DAIL and DMH staff quarterly for group education and training, case consultation, networking and sharing of challenges, best practices and strategies.

For more information or questions about the statewide ECC program, please contact:

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Participating Agencies:

Designated Agencies Currently Providing Elder Care:

Counseling Services of Addison County
Northwestern Counseling and Support Services
Howard Center
Healthcare and Rehabilitation Services of Vermont
Northeast Kingdom Human Services
Rutland Mental Health Services
Washington County Mental Health Services

Area Agencies on Aging Contracting for Elder Care:

Age Well
Central Vermont Council on Aging
Northeast Kingdom Council on Aging
Senior Solutions
Southwestern Vermont Council on Aging