

Project Narrative Comprehensive Systems Reform Effort

I. Identification of Problems or System Issues

A. Background and Identification of Problems

The application demonstrates a thorough understanding of the State's long-term care service systems reliance on institutional services, opportunities for increasing HCBS supports, and increasing the opportunities for self-direction

Vermont is a small, rural state of 600,000 people, with a historical commitment to providing services and supports in integrated, community-based settings. For over 30 years, the State of Vermont has had a policy of helping elders and adults with physical disabilities live with dignity and independence. Vermont's aging population and growing number of adults with physical disabilities will generate increased demands on the long-term care system. Vermont's population is projected to grow 4.5% from 2003 to 2013. The fastest growing groups are the eldest cohorts, those 85 and older, which will expand 27% and those 74-84 will expand 9% during this time period. For younger adults (18-64), the disability trend is on the rise. The prevalence of disability will climb by 3.1% annually for the next 5 years and another 2.6% annually for the period 2008-2013.

In 1996 the Vermont Legislature enacted Act 160. Act 160's intent was to fortify Vermont's home and community-based system by infusing new funds previously reserved for institutional care. Consumers have come to expect and request high quality home-based long-term care. At the inception of Act 160, public expenditures for in-home and community-based care were 11.6% of the total long-term care budget. The estimates for FY'04 show a rise to 30%. In 1992 approximately 22% of Vermont's 85+ lived in nursing homes. In 2002, that number has dropped to less than 15%. This decline is expected to continue into the future. For example, the percent of

elders aged 85+ using nursing home care is projected to decline 3.5% annually. In 2003, there were 3,835 Vermont adults with physical disabilities and elders living in the community who required assistance with at least two activities of daily living (ADLs). Almost half of these individuals were low-income (below 175% of the Federal Poverty Level). By 2013, the total will expand to 5,464, a 42% increase. This shift underscores the importance of moving resources from institutional care to home and community-based options. In addition, the need for better coordination of care across providers of both long-term care and primary/acute care services is critical.

In the current long-term care system Vermont is served by 5 Area Agencies on Aging, 18 adult day sites, 110 residential care homes, and 43 nursing homes. In addition, there are 12 home health agencies. Vermont is unique because there is only one Certified Home Health Agency per designated area. The certificate of need process eliminates competition among home health agencies. Home Health Agencies are required to serve everyone.

Ten Community Long-Term Care Coalitions were created in response to both the Legislative mandate in Act 160, and the State's desire to work in partnership with local communities to improve the long-term care system. Coalition membership consists of consumers, providers, advocates and other community members committed to improving the quality of life and quality of care for Vermonters receiving long-term care services.

In 1983 in response to consumer demand the state instituted the Attendant Services Program. Attendant Services Programs (Personal Services, Participant-Directed Attendant Care, and Group-Directed Attendant Care) are designed for people 18 years and older with physical disabilities. The average age of an ASP participant is 56, with an age

range of 19 to 99. Since its inception consumers hire, train and supervise their own caregivers. Initially all ASP services were only funded with state general funds. In 2001, the State developed a Medicaid “entitlement service” with the Attendant Service Program. Approximately 20% of the participant’s services are reimbursed by Medicaid.

Vermont’s 1915(c) Medicaid Home and Community-Based Services Waiver program provides services to 1,300 elders and adults with physical disabilities who would otherwise require placement in a nursing home. The average age of waiver participants is 72, with an age range from 18 to 101 years. Consumers can choose to have an agency manage their services or they may select consumer or surrogate directed options. Services under the Home-Based Waiver include personal care, adult day services, respite, case management, assistive devices, and home modifications. Home Health Agencies are responsible for providing personal care, case management and respite; Area Agencies on Aging provide case management. Adult day centers provide adult day services and respite. Assistive devices and home modifications are provided on an individual basis. Under consumer and surrogate directed options, individuals employ their own caregivers.

In October of 2003, the State of Vermont submitted an 1115 Long-Term Care Waiver to CMS. This proposal for a long-term care demonstration program is a result of a year-long planning and development initiative. The proposed program addresses both shortcomings in service availability and the inherent bias in the current funding mechanisms for long-term care. This demonstration is aimed at equalizing the entitlement to nursing home care and home and community based serviced for adults with physical disabilities and the frail elderly. Individuals who can maintain themselves in the community, with home and community-based services

should have that option. Under the existing federal Medicaid system individuals are entitled to a nursing home bed, but have to wait for a “slot” to get home and community Based services.

CMS is still reviewing the current proposal.

The Office of Vermont Health Access (OVHA), the State Medicaid Office, and the Department of Aging and Independent Living (DAIL) historically have worked in partnership to ensure that elders and adults with physical disabilities live as independently as possible, actively participating in and contributing to their communities. The Vermont Independence Project, (VIP) is a collaborative effort involving the OVHA and DAIL. VIP received funding from the Robert Wood Johnson Foundation’s “Medicare and Medicaid Integration Program”, (RWJF/MMIP) and the John A. Hartford’s “Accelerating States Access to the Program for All-Inclusive Care for the Elderly”, (ASAP/PACE) grant. Through the work of the Pacific Health Policy Group, Vermont Program for Quality in Health Care, and the Dartmouth Medical School, the VIP has linked Medicare and Medicaid Claims data for calendar years 1996-1999. The linking of this data has shown that 43% of the entire Vermont Medicaid budget is spent on 10% of the Vermont Medicaid population. This is the population that is entitled to both Medicaid and Medicare. Individuals with both Medicare and Medicaid are often those in need of long-term care and/or have chronic health care conditions.

To respond to these costs, the Vermont Independence Project established The Care Partner Program. Its purpose is to provide a team approach to the total health care needs of low-income elderly and physically disabled Vermonters, and to help people live safely at home. The Care Partner Program is a pilot effort involving two of the state’s ten Long-Term Care Coalitions: Franklin/Grand Isle County Advocates for Long-Term Care and Windham County Long-Term Care Network.

The program is designed to co-locate Area Agency on Aging case managers in primary health care practices. A total of eight physicians participated in the pilot project; four in Windham and four in Franklin County. Seven case managers worked with these physicians and their staff. Physicians made referrals to case managers who then met with elders or persons with disabilities in the physician's offices or other locations, primarily individuals' homes.

A qualitative evaluation of the Care Partners Program was conducted by Geller and Dorwaldt Associates, researchers at the University of Vermont. A quantitative evaluation was conducted by Joy A. Livingston, Ph.D. of Flint Springs Consulting. From these two evaluations recommendations were:

- Continue and expand the program
- Maintain one case manager working full time in a large practice or traveling within a small community to all the Primary Care Physician's offices
- Require PCP and case manager to communicate at least once a week
- Provide space in Physicians office
- Include assessments from both clients and physicians as well as case managers
- Link data to both the Medicaid and Medicare claims processing system.

The participating physicians were satisfied with the program and no problems were reported.

However, the case manager's major concern was about the need to feel part of the team.

Although the grant funding ended on 12/31/03, the program was so popular that two physicians and two Area Agencies on Aging are continuing the program without grant funding.

The VIP program has been actively involved in development of PACE centers in Vermont. The VIP program worked with the Champlain Long Term Care Coalition (CLTCC), serving Chittenden and southern Grand Isle Counties, and the Rutland Long Term Care Coalition serving all of Rutland County. The coalitions are collaborating together to develop and implement PACE centers. The plan is to establish one PACE Center on the Fanny Allen Campus of Fletcher Allen Health Care at the adult day program sponsored by the Visiting Nurse Association of

Chittenden and Grand Isle Counties. A second PACE Center is planned in Rutland City in a senior housing development near the Rutland Regional Medical Center and Rutland Area Visiting Nurse Association.

Vermont submitted a state plan amendment to CMS and received approval to offer PACE as a service. The two local Long-Term Care Coalitions have formed a non-profit corporation in Vermont and are in the process of applying for 501 c 3 status with the IRS. In 2004, the Vermont General Assembly appropriated PACE Vermont \$100,000 for start up funds. The two major hospitals involved are ready to authorize letters of credit for additional capital funds. PACE Vermont plans to open their centers in the summer of 2005.

Vermont has been forward thinking in the development of other long-term care programs. This includes consumer/surrogate directed programs, attendant services programs, and management of Home and Community Based Services; however, the current programs do not take into consideration the total needs of the individual (health care and long-term care). The current programs only coordinate long-term care services. Based on what was learned through the VIP program, the problem we hope to address through this grant is to create a system for frail, vulnerable, chronically ill adults that will be truly integrated to meet a person's complete complex medical and long-term care/social needs. These individuals might not be eligible for PACE or because of where they live the PACE site is not available. However, a PACE like model, like the coordinated care models in Massachusetts, Minnesota and Wisconsin will be analyzed as part of this planning process of this grant.

The Applicant lists and describes all CMS Real Choice Systems Change Grants currently funded within the applicant's State and clearly explains how the proposed activities will not duplicate activities currently funded by such CMS grants.

Vermont currently has one Real Choice Systems Change grant from CMS. The goals of the Systems Change grant are to effect enduring systems change that:

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

The objectives are to:

Objective 1: Information and Assistance. Improve and coordinate mechanisms across systems to provide consumers with easy access to independent, consistent and accurate information, and assistance in navigating service delivery systems.

Objective 2: Self-Advocacy, Self-Determination and Recovery Education. Identify best practices to foster self-determination, self-advocacy and recovery among consumers and develop methods for expanding implementation and availability of those practices.

Objective 3: Workforce Development. Create a valued, adequately reimbursed and well-trained workforce across the three systems.

Objective 4: Development of an 1115 Long-Term Care Medicaid Waiver. Develop an 1115 Long-Term Care Waiver to increase use of home and community-based services (HCBS) and eliminate the Medicaid bias toward nursing homes.

Objective 5: Direct Consumer Funding for Developmental Services. Research the option and implement a pilot project for providing direct funding for supports and services to people with developmental disabilities and their families.

The objectives being developed under the existing Real Choice Systems Change grant will be very helpful to the proposed new initiative, but will not be a duplication of effort. The development of the 1115 Long-Term Care waiver will increase access to home and community based services for long-term care needs. However, it does not address nor coordinate the medical

care needs of Medicaid participants who are frail, vulnerable, chronically ill elderly and physically disabled adults.

B. Analysis of Strengths and Challenges

The application describes the barriers (and a plan to address those barriers) facing the State as it attempts to develop and implement a comprehensive reform plan.

Vermont's current approach to the management of health care services for Medicaid beneficiaries has transitioned from a risk-based capitated model employing commercial managed care organizations to a primary care case management program that involves direct payments to primary care providers who agree to serve as 'medical homes' for their patients. Medicaid beneficiaries are eligible for the "medical home" program if Medicaid is the only source of insurance. The current Primary Care Case Management system does not fully meet the needs of Dual eligible population since people with complex needs often have more than one insurance. This proposal hopes to address this barrier by reforming the system to develop specialty plans.

The development of PACE in this state has proven beneficial in the development of this grant proposal. The interest in the team approach to care as offered under the PACE model has developed an interest by provider organizations to expand and create other care coordination models. Vermont's system reform idea is to provide incentives to organizations to utilize the interdisciplinary team approach to care coordination of both long-term care and primary/acute care needs. This system reform will fit well in Vermont, due to the rural nature of the state, where transportation is a challenge. This system reform for dual eligibles in Vermont will provide eligible Vermonters an option in addition to PACE and the 1115 LTC waiver. Some of the barriers that will arise in developing this reform will include the rural nature of the state and how to involve small physician practices that provide services to a variety of individuals. These

are barriers in establishing specialty plans for dual eligibles as with any capitated payment based model, the number of eligible beneficiaries both eligible and enrolled in a specialty plan is critical to the success of that plan. Another barrier will be developing the system of care coordination. In the Care Partners program, Area Agency on Aging case managers were utilized as Care Partners. In another pilot project in Vermont, funded by the Long-Term Care Coalitions, a care coordination model used a nurse and a social worker working as a team. This is similar to the Senior Care Organization model that has been adopted in Massachusetts. The Office of Vermont Health Access and the Department of Aging and Independent living will work together to overcome this challenge and collaborate with community partners to develop an integrated care system that will work in Vermont.

C. Problem Analysis

The application evidences an identification, understanding, and analysis of the scope and nature of the specific problems or gaps that the proposal is addressing.

Working with consumers on the existing Systems Change Grant and the development of PACE has provided ample opportunity for feed back. Both projects conducted extensive focus groups and surveys. Some of the current frustrations experienced by consumers and service providers include; delays for services that are needed immediately, failure to approve services that are clearly necessary; poor follow through with approved services; poor communication across systems: scheduling that is inconvenient; lack of coordination between health care and community support systems; and failure to honor consumer choice. Despite these problems, providers in both long-term care and health care do the best they can under the circumstances. One of the highest ranking concerns for consumers was “peace of mind.” This was best

expressed by one focus group participant “as knowing someone cares and getting proper care contributes to healing.”

This system reform would pilot a redesign of the systems in Vermont to build on what has been learned from the PACE model, VIP Care Partner Program and the success of the waiver programs in Vermont. A commitment to integrated care is the starting place for the reform. Separation between health and long-term support systems and the discontinuity across service delivery settings and providers will guide the development of the reform. The target population includes individuals with complex medical needs, this consists mainly of people who use multiple providers in both health and long-term support systems. Integrating care across systems would be done through the use of integrated funding and the interdisciplinary care management teams in alternative settings. The alternative settings/ providers may include and are not limited to Area Agencies on Aging, Home Health Agencies, Hospitals and Provider Hospital Organizations.

Another gap in the current system is the involvement of the consumer in his/her own care. This reform will strengthen the role of the consumer in planning and evaluating his/her own care. Organizations that have a health care base have challenges integrating consumer participation and maintaining a focus on quality of life, while organizations that provide social services and long-term care will be challenged to understand the financial and physical risk of providing health care services. To truly integrate the two systems, health services are subsumed under quality of life. Health services are for the purpose of better quality of life rather than an end in and of themselves. While health services remain an essential ingredient in the overall plan, they do not automatically take precedence over everything else.

II. Project Description and Methodology

The are clear goals and objectives that relate in a meaningful way to the problem identified above and those goals and objectives are reasonable and are likely to be effective in accomplishing the purpose of the grant.

A. Goals and Objectives

Goal: The goal of this Comprehensive Systems Reform Effort Project is to plan, design and implement organizations that integrate funding streams, and integrate acute/primary and long-term care service delivery as an option for frail, vulnerable, and chronically ill elderly and physically disabled adults. The purpose for creating these organizations will include the following:

- Enhance consumer quality of life and autonomy
- Enable, promote, and support consumer's ability to live at home and in the community as long as medically and socially feasible
- Preserve and support consumer's family units
- Provide person centered planning, thus putting consumer's in the middle of their own planning.

Objectives:

- Provider Organizations:
 - Improve the quality and coordination of care provided to consumers
 - Expand consumer's access to covered services.
 - Maximize consumer satisfaction with services provided.
 - Maximize the ability of consumers to live in their own homes, to participate in community life, and to be engaged in the decision-making processes regarding their own care
 - Minimize reliance on institutional care
- State:
 - Increase the cost effectiveness of care.

- Develop and implement a self-sustaining system that includes program and organizational development, model improvement and replication
- Create a design whose essential elements can be applied to multiple age and target groups in various geographic settings, urban and rural
- Secure appropriate waiver and/or specialty plan program approval from CMS
- Researching to ensure and improve quality during the grant
 - Carefully research and document implementation experiences and consumer responses
 - Develop and test quality assurance protocols and quality indicators based on the expressed values of consumers.

B. Methods of Effectively Addressing the Problems

The proposed strategy to develop and implement a comprehensive reform plan must address all the following components:

- *A coordinated planning and system management effort that involves key stakeholders including State agencies responsible for program oversight, individuals with disabilities and their advocates, and providers of services.*

Strategy: To accomplish coordination planning and system management a core planning team and a community advisory task force, will be developed.

The ability for this system reform to provide comprehensive, integrated care depends on good working relationships with a wide range of providers and respect from the general community. The challenge for building a successful reform is to cultivate this extensive network early in order to be seen as credible and to assure that consumers will have access to all the services needed. Relationships will need to be built with both community stakeholders and

members of the current service network such as hospitals, physicians and consumer rights groups. The lead state agency responsible for program oversight will be the Office of Vermont Health Access with assistance from the Department of Advocacy and Independent Living.

The primary goals of the core planning team are to oversee the development of the system reform including assessment of the infrastructure necessary and the capacity to develop an integrated model. Members will include the project director, individuals with expertise in finance, information systems, quality, service delivery, marketing/public relations, and medical director. The key activities will include: development of care delivery and administration policies and procedures; define target populations; define how the reform will add to rather than detract from what is currently available: develop data and reporting requirements; define information systems; establish reimbursement rates, build protocols for care management teams, identify provider networks; secure contracts with service providers; develop how quality will be monitored: and build awareness in the community. This committee will meet bi-weekly to accomplish all of these activities during the grant period.

The Community Advisory task force will focus on several major objectives: Identifying and educating potential service providers advising the core planning team in the development of the system reform to ensure that the reform meets the unique needs of the community and consumers, and creating community allies. Members will include consumers, consumer advocates, health care providers, long-term care providers, other not-for-profit service providers, governmental agencies, and local and state officials. Lessons learned from the first Systems change grant in Vermont have guided the make-up of the Community Advisory Committee. It was learned from consumers that they wanted to serve on committees as equal stakeholders in

the process so their opinions could be heard. One facilitator will be hired to run all of the meetings.

It is important that all stakeholders have a chance to express their concerns and make suggestions, have their voices heard, and see how their input may be reflected in the end result of this reform. For success, there will be interaction between the Core Planning team and Community Advisory task force. It is important that planning team members work interactively with the Community Advisory task force on program planning and implementation. Consultants will be hired to develop expertise in finance, operations, information systems, quality, service delivery, and marketing/public relations, and clinical oversight.

- *Improvements in how individuals access long-term supports including interventions that (a) target pathways to institutional supports, (b) speed up the eligibility determination process, and (c) facilitate the ability to make informed choices.*

Strategy: Develop policies and procedures for interdisciplinary team to manage the long-term care and health care needs of persons with disabilities, chronic illnesses and challenging life issues.

The system reform will include improvements for individuals in accessing long-term care supports by promoting creativity and flexibility in problem solving, while remaining cost-effective in delivering care to persons with physical disabilities, chronic illnesses and challenging life issues. All services, including primary, acute and long-term care services are provided based on assessed need and as medically necessary. Enrollment in this system for consumers will be voluntary. The consumer always has the choice to disenroll from this system and return to the fee-for-service system. The provider organization, except for very rare circumstances, has the member for the duration of his/her life. The core interdisciplinary team

includes, consists of the consumer, the Primary care provider, Nurse Practitioner, Registered Nurse, Social Worker and team assistant. The team is the cornerstone of the reform and will be responsible for targeting pathways to institutional supports, speeding up the eligibility determination processes, and facilitating the ability to make informed choices. To accomplish the above, this team facilitates close, ongoing communication and ensures a single, coordinated approach to care by all providers. In addition, the team will work very closely with the state in the eligibility determination process and assist as needed with information gathering and advocacy on behalf of the consumer. A single plan of care is used by all team members.

Engaging the consumer in expressing his/her own goals and participating in decision-making, guide the team in planning care with a quality of life focus. Social and medical needs are interwoven and thus considered jointly. The team will provide some care directly and is ultimately responsible for the delivery and overall quality of care the member receive from all providers. Authorization of service, with few exceptions, is from the team. The team meets regularly to discuss and problem-solve issues and to plan and evaluate care. The team interacts with the consumer and other providers in all settings he/she may access for medical, social or long-term care needs. Being involved in all aspects of care delivery allows for ongoing advocacy by the team and usually provides a deeper sense of trust and security for the consumer.

Efforts to remove barriers with State budgets that prevent funds from moving from allocations earmarked for institutional supports to home and community based supports.

Strategy: Eliminate cost shifting between and among various funding streams now experienced in the state budget through integration of funding.

In Vermont, there is currently no barrier that prevents funds from moving from institutional supports. In 1996, Vermont implemented Act 160 that required the shifting of funds from

institutions to services provided under the 1915 c Home and Community based waiver. The biggest barrier is the federal entitlement to nursing home placement for consumers. This entitlement makes it difficult to control spending. To coordinate with the work of Vermont's 1115 LTC waiver, one of the most important steps in the reform is to remove this entitlement barrier and integrate funding for a subset of the eligible population. The system reform initiative will develop policies to integrate funding streams for Medicaid, commercial health insurance and Medicare. Funds will be integrated into capitated payments. The Coordinated care/PACE like organization will be at full risk for expenses. Medicare Prescription Drug, Improvement and Modernization Act of 2003 allows for Specialized Medicare Advantage Plans for special needs beneficiaries. One of the groups defined in the act as special needs are individuals with Medicare and Medicaid Coverage. Commercial managed care has not been successful for Vermont Medicaid. However, if organizations were allowed to focus on subpopulations and be reimbursed a capitated payment based upon acuity this would replicate the success of models such as Wisconsin Partnership and Massachusetts Senior Care Organizations and Minnesota's Senior Health Options and Disability Options.

These Coordinated Care PACE like organizations will complement the work of the 1115 LTC waiver. The 1115 LTC waiver will serve the long term care needs of most elderly and physically disabled long-term care Medicaid eligible Vermonters. These PACE like organizations will serve both the long-term care and primary/acute care needs of the same population who voluntarily participate in this coordinated care model instead of the 1115 LTC waiver option. When resources are pooled instead of sending the consumer to a Nursing Home because there is not enough funding for home based services, the organization is financially responsible for these costs in all settings. Thus, using the providers appropriately or creatively to

develop alternate plans to meet the consumer's needs is also in the best interests of the program. This liberates the team from the restrictions associated with budget restrictions and encourages the development of creative solutions. In addition, Vermont hopes to demonstrate the same budget impact as shown in Wisconsin with this type of reform. The initial data in Wisconsin demonstrates a notable reduction in hospital and nursing home placement than they had previously in the fee-for-service system. Wisconsin also experienced a reduced rate of hospitalization and emergency department visits for ambulatory care sensitive conditions. This reduced utilization is the result of better care coordination and by implication improved access to preventative care.

Efforts to alter how institutional and home and community based service are financed to remove barriers to individuals with disabilities or long-term illnesses remaining in the community and increase the level of control held by them and their families.

Strategy: Increase service flexibility, better communication and responsiveness and increased payment flexibility through integration of funding and networks.

The financing will be changed to a capitated payment instead of a fee-for-service payment system that leads to fragmentation of care. The individual will have one care plan instead of two that may or may not be compatible or consistent with each other. There are a variety of benefits for integrating funding streams. These include increased service flexibility, better communication and responsiveness and increased payment flexibility.

The service flexibility is important because consumers and providers will not be limited to a pre-established list of services for a diagnosis or a population. The team is authorized to determine what is needed, and to purchase the medically necessary services or resources. The challenges of prior authorization are eliminated, which provides a timelier and less bureaucratic

process. Consumers are not automatically entitled to services on a “covered” list. Rather, they are determined on an individual basis.

The system reform will be structured to provide strong incentives and resources for contracted providers to collaborate with the interdisciplinary team. Incentives will include providing payments that are more in line with market rates, providing reasonable payment for services that are not generally reimbursed and having a contact person at the agency to address problems.

Integration of funding streams will also result in increased payment flexibility. The system will also have the flexibility of providing a higher level of service and rates than those traditionally covered, as well as services that are tied to consumer characteristics such as transportation to a volunteer activity to help with depression or relaxation tape to address anxiety. This is an important mechanism for responding to the needs of individuals members, allowing care plans and services purchased to be better tailored to individual needs. Current limits on certain therapies can prevent care providers from using the services they know to be beneficial. Flexibility in this system reform would allow the interdisciplinary team to approve additional therapy.

In addition, the reform will support and encourage the involvement of consumers in identifying treatment goals. Assessment and treatment plans are designed to assist consumers to achieve the goals that are most important to them as well as to promote high standards of care. Thus consumer expertise is combined with the wisdom and expertise brought by the care management team and other providers. Understanding what the consumer wants and what their life goals are may change a decision for care or treatment. Traditionally consumers have been invited to participate in determining “how” a goal is achieved, in the system reform consumer

will participate in “what” goal is achieved. An important role of marketing/public relations expertise will be to communicate this message to providers and consumers.

Efforts to ensure that service are available that match the needs and preferences to the individuals that receive them, including efforts to improve supply (e.g. workforce development) or practices (e.g. training)

Strategy: Development of policies and procedures, and feed-back loops for team collaboration with service providers to provide integration across sites and providers.

This system reform should help ensure that services are available that match the needs and preferences of consumers. The collaboration of the team is at the heart of the program directly linking care from hospital to home, nursing home to home, hospital to nursing home, and across providers. This constant evaluation by the team will help to ensure the necessary feedback loops are in place to ensure best practices. This will be done by:

- Subcontracting with service providers that provide clear links, collaboration and information sharing with the team,
- Direct contact with team members and through care providers in home, clinic and residential or acute care settings, and
- Using flexible payment mechanisms described previously to provide incentives to improve the supply of services.

There are a variety of benefits for integrating funding streams. These include increase service flexibility, and better communication and responsiveness and increased payment flexibility. In addition, this collaboration should increase job satisfaction. Improved job satisfaction would improve the supply of workers and improve practices. Some of the original work on job satisfactions was published in *Work Redesign* by Hackman and Oldham (1980). Hackman and

Oldham found five core job characteristics were necessary to improve motivation. The core job characteristics are: skill variety, task identity, task significance, autonomy, and feedback from job. The use of team management will incorporate the five core job characteristics necessary to improve motivation, this improving best practices and job recruitment at all levels. This new model of care will eliminate a hierarchical structure and allow team members and consumers to make timely decision regarding care and allocation of services. This assumption is supported by a survey conducted in 2001 by the Vermont Department of Aging and Independent Living. PCAs and LNAs identified the three top reasons that kept them coming to work each day. The three top reasons were: rewards of caring for people; feeling responsible and knowing the job is important; and respect and caring from their clients/patients. By reforming the system that includes all providers as part of the team should address the motivational factors to improve retention. This will lead to increased resources and better care.

Funding integration will also allow for the team to decide to pay higher or different rates for necessary services. As in the Cash and Counseling model, if homemaker services such as shopping or cleaning are needed it could be done by a neighbor at a different rate than what is paid to a personal care assistant. This would help to free up the labor pool of the more skilled services workers for such tasks as bathing or transferring. The decision would be made by the team with the consumer included in the decision process deciding the most appropriate way to deliver services.

Building quality management systems that reflect the desire of individuals to direct their own services.

Strategy: Develop methodology to incorporate quality research from consumers, soliciting ongoing participation from consumers, using published research to guide program design,

and procedures to maintain high technical standard of care to guide every aspect of the program.

The integration of funding would also allow for the design of systems that are committed to providing consumer centered care. This is not something that would be added to the care plan or that would be the responsibility of any single team member or discipline. The only reliable way to achieve “consumer-centeredness” is to build it into every aspect to the program and organization, from the design of information systems and quality improvement processes to the development of job descriptions, recruitment and selection of every staff member, funding mechanisms, contracts with providers, policies and procedures, and the overall structure of the organization. While giving consumers choices and honoring their preferences is often an appropriate strategy when selecting supportive services, integrating consumer choice and preference is much more challenging with health and medical issues. Neither consumers nor providers are generally comfortable with consumer choice as the sole guiding principle for health and medical decision making. Integration of consumers will be achieved through multiple strategies. To ensure the reform has the level of control desired by consumers and their families the following activities that will be part of reform: quality research from consumers; ongoing participation from consumers; published research to guide program design; and maintaining high technical standards of care.

The reform will include a research project to determine what is important to consumers in Vermont. The reform will include an intensive ongoing field research program. The purpose of the research will be to learn from consumers in the program how to design and deliver consumer centered care.

Ongoing participation from consumers would be sought in both planning and evaluation of care and service quality. Assessment and treatment plans will be designed to assist consumers to achieve goals that are most important to them, as well as to promote high standards of care. Involving consumers in developing one plan of care, and identifying the goals to be achieved will be vital.

Published research and advocacy groups on consumer preferences will be used to guide the initial program development. Research and other available information related to consumer experience will be used to develop initial care plans. An example of other types of available information, would be to learn from existing consumer experience in Vermont. Vermont has successfully run a consumer/surrogate directed Attendant Services Program (ASP) for elders and adults with physical disabilities. This program provides personal care services. One of the biggest successes is consumer involvement in ASP. The ASP has a statewide eligibility committee. This committee is composed of at least three members, one is a staff person from the Agency of Human Services, and all other members are consumers with disabilities. After the completion of an independent assessment, this committee is responsible for reviewing the assessment and making the decision on the hours of personal care allowed. Informed by the ASP and published research on such issues as preventing hospitalization, appropriate physical therapy to prevent decline from inactivity, and creation of medication monitoring systems to prevent medication errors are examples of how research literature will be used to guide program design.

Another strategy to build a consumer centered system is to provide high technical standards of care. In addition team members will have both expertise relevant to the population served and they will actively pursue continuing education. The member of the team will be committed to, and actively involved in evaluation and acquiring skills that they do not have.

C. Coordination and Linkages

The OVHA will work in coordination with the Governor's office, Agency of Human Services, AHS, and other public and private partners on this project. The AHS is leading a Chronic Illness Care initiative on behalf of the Governor's office for all Vermonters based on the work of Dr. Ed Wagner, of the MacColl Institute for Healthcare. One of the components of the Governor's Chronic Illness care initiative includes ongoing, coordinated care across many settings. These Vermont Chronic Illness care stakeholders/partners are committed to the success of this reform. These two initiatives should complement each other and this project will serve a subset of the general population but will follow the Chronic Illness Care model.

The OVHA worked in partnership with the DAIL to develop the PACE project, the same model will be used to develop this system reform. The partnership of DAIL is critical since they manage the programs providing long-term care. This reform will integrate long-term care and health care services for individuals.

Vermont's long-term care and health care systems utilize local non-profit agencies. These provider's involvement is important to the success of enduring systems change. They have expressed support and cooperation for the objectives of this systems change. See, letters of Support and Commitment. Local service providers will be included in all phases of the design, implementation and ongoing evaluation of grant activities by serving on the community advisory task force.

When the State of Vermont and the Vermont Center for Independent Living co-sponsored a Citizens' Forum in June of 2003, the energy and excitement about consumer centered care was clear. This forum was attended by 250 consumers. The following themes emerged from the forum as important:

1. Non-medical model & language
2. Mutual respect-mutual benefit
3. Living wage for providers
4. Ability to make choices, flexibility/adaptability to meet needs
5. Persistence
6. Applicable to local/Vermont situation
7. Adequate funding & resources
8. Ability to have flexibility with funding

These themes gave a clear message that the next step State administrators needed to consider were additional reforms in Vermont systems. These reforms should include consumer-centered care and coordination between long-term care and primary/acute care. Additional forums will be used to include consumers as collaborators and partners in addition to the consumers serving on the community advisory task force. The use of the annual forum will include as many consumers as possible in the development and education process.

D. Work Plan

Parties responsible for the accomplishment of project goals are identified.

The OVHA will be the lead agency and the responsible party for accomplishment of the project goals. Staff from the OVHA and DAIL will be involved in the planning process, which will be at least an 18-24 month period. In the last year of the grant organizations will be piloted based upon the planning and feasibility work of the first two years of the grant. The project director will work with the core planning team to develop the specifications for the model. The community oversight task force will have final review and approval of details of the model that include:

1. Highly coordinated across providers, settings, and overtime,
2. Comprehensive in services of high technical quality,
3. Consumer centered,
4. Delivered in a way that led to a positive experience for consumers,
5. Appropriate for non-elderly as well as for elderly consumers, and
6. Cost effective

After development of the model the community task force and core planning team will develop and issue RFPs to provide seed money to interested provider organizations. The selected provider organizations will work with the state on the rest of the planning including:

The core planning team will work to achieve all the milestones listed below. Work will not be finalized without the review and approval of the community advisory task force.

There is a work plan that provides milestones for all of the following components:

Coordinated Planning and Systems Management - Milestones

- Develop, and issue RFP for contractors with expertise in finance, operations, information systems, quality, service delivery, marketing/public relations and medical director to form planning committee.
- Form Community Advisory Committee.
- Select contractors with Community Advisory Committee.
- Define target population – financial and clinical eligibility.
- Initial Policy Development – Legislative Changes, Service Provider Licensure, Risk-basked entity licensure.
- Develop policy and procedures for administration, care delivery, enrollment.
- Solicitation and selection of provider organizations.

- Synthesize all data analysis and create a business plan that outlines the feasibility of creating integrated care organizations for a subset of Vermont's dual eligible population
- Develop an integrated care organization for a subset of VT's dual eligible population

Contractors and key state staff from the planning team will work with the selected provider organizations to achieve the milestones outlined below.

Access-Milestones

- Define core interdisciplinary team members.
- Define relationship of primary care provider to the team.
- Define the role of the consumer in planning and evaluating care.
- Define services to be provided by team members.
- Define services to be contracted by the team.
- Develop operational structure to promote collaboration and care integration.
- Develop single care plan to be used.

Finance: State Budgeting-Milestones

- Research spending by the target populations in various state Medicaid programs.
- Identify services currently being reimbursed by Medicaid.
- Cost shifting from other insurance.
- Financial review of documentation for the upper payment limit and rate setting.
- Develop a Medicaid Capitation Rate.
- Research current regulations from CMS for 1115/222 Medicaid/ Medicare waiver or Medicare Specialty Plans, or a Medicare Advantage Plan
- Develop strategy for application to CMS for integration of funding & seek approval from CMS as appropriate.

Finance: Individual Services and Supports-Milestones

- Develop guidelines for the team to use in the development of creative solutions for care.
- Develop guidelines for increased payment flexibility.
- Develop guides for the involvement of consumers in identifying their treatment goals.

Type and Supply of Services-Milestones

- Development of feedback loops and incentives to ensure best practices.
- Develop systems to nurture and support an effective and highly collaborative interdisciplinary team to increase retention and job satisfaction.
- Develop funding integration to pay higher or different rates for needed services.

Quality Management-Milestones

- Develop clear definition of consumer-centeredness that is incorporated into every aspect of the program.
- Conduct research on what is important to Vermont Consumers; review published research on consumer preferences; and interview Vermont and national consumer advocacy groups to determine their priorities on consumer preferences.
- Working with the Quality consultant to conduct research and develops a guide to be used for initial program development.
- Working with the Quality consultant to design systems to solicit on-going participation from consumers in both planning and evaluation of care and quality service.
- Develop systems to ensure high technical standards of care

Evaluation Plan that includes plans for both process and impact evaluation

The plan is to hire researcher/s to conduct both process and impact evaluations as an on-going part of the process. The evaluators will review and document and summarize into reports

the process used by the State, the core planning team and the community advisory task force to achieve the measurable outcomes of the project. This element will provide feedback during the process and documentation and information to replicate the process for other populations or other states. In addition, during the process the evaluators will conduct qualitative evaluations to determine the impact of the project on them or their organizations. This will provide information to the state to determine if there is any need to change directions.

E. Organizational, Management, and Qualifications

Specific circumstances that would affect the ability of the State to recruit and hire project staff are identified (e.g., current hiring freezes or other obstacles) as are the methods by which such obstacles will be overcome.

The only administrative barrier the State anticipates is the time necessary to receive state approval to spend the grant funds. Even though this initiative is supported by the Governor once the funds are awarded by CMS there is a legislative requirement to receive approval from the joint fiscal committee before funds can be spent. This project will be led by an existing state employee, and therefore the delay in implementation should be minimal.

Key project staff, stakeholders, and partners are qualified and possess the experience and skills to design, implement, and evaluate the program within the available time frames.

Joan Haslett, MSA will be the project director. Joan has had twenty-five years of public service. Currently she is a Primary Care Plus administrator in the Long-Term Care Unit for the OVHA. Currently she is the co-director of the PACE initiative in Vermont and coordinates with DAIL on the planning for the 1115 Long-Term Care Waiver. She was the Project Director for the first Real Choice Systems Change Grant in Vermont in her previous position for the DAIL. In addition, she collaborated with the OVHA co-directed a grant from the National PACE Association to expand the PACE program to Vermont and co-directed the Vermont

Independence Project Care Partners program funded by a grant from Robert Wood Johnson Foundation Medicare and Medicaid Integration Program. In this position she managed several research and evaluation initiatives; including the annual consumer satisfaction survey of individuals receiving long-term care services from the DAIL; writing a legislative report to study the aging population (50+) and their preparation for retirement and long-term care; and the development of an successful aging report analyzing the Behavioral Risk Factor Surveillance System data for the elderly and disabled population in Vermont. In addition, she was the administrative officer for a health department in a small rural county in upstate NY, this included responsibility for operating the county Home Health Agency. She has also worked at the Vermont Department of Health developing the Healthy Babies case management program.

Brendan Hogan, Director of Long Term Care Services, Office of Vermont Health Access. Manager for the Vermont Independence project's RWJF/MMIP grant funded Care Partner program as well as the Hartford Foundation funded National PACE Association's Accelerating States Access to the Program for All-Inclusive Care for Elderly grant. He coordinates with DAIL on the 1115 LTC waiver proposal. In addition Mr. Hogan is the External Quality Review Contract manager for the OVHA overseeing the work of the Vermont Child Health Improvement Project and the Vermont Program for Health Care. On behalf of the OVHA, he assists the Medicaid director with the work of the Governor's Chronic Care Initiative. Mr. Hogan is a staff level member of the Centers for Medicare and Medicaid Services' Dual Eligible Technical assistance group. Mr. Hogan has worked a for large hospital system, a private health care insurance company, a state insurance department as well as his current work at the Office of Vermont Health Access.

J. Scott Strenio, MD, Medical Director for the Office of Vermont Health Access, Board Certified in Family Practice, nearly 20 years as a physician with experience both as a general practitioner in Pennsylvania and Vermont. In addition his experience includes: Medical Director for the Community Health Center in Burlington Vermont; Delmarva Foundation; and Correctional Health Care Solutions. He has experience as a volunteer physician for the Intersection shelter in Pittsburgh and as an instructor at the University of Pittsburgh Medical School. His role will be the lead clinical advisor for this project.

Joan Senecal, Principal Assistant to the Commissioner, Department of Aging and Independent Living, oversees numerous programs, services and grants that help elders and younger adults with physical disabilities maintain their independence. She has eight years experience developing ways to enhance the home and community-based care system in Vermont and is the lead for DAIL on the Governor's Chronic Care Initiative.

Bard Hill, Director, Division of Advocacy and Independent Living, Department of Aging and Independent Living, is responsible for the administration of the; Home and Community Based Waiver, Homemaker and Attendant Services Programs at DAIL. He has spent 11 years working with Medicaid-funded home and community-based programs.

Key project Staff has direct professional experiences with individuals of any age who have a disability or long-term illness.

Alexis McLean RN, Nurse Case Manager with the Office of Vermont Health Access will provide clinical expertise in the development of the service delivery for the model. Ms. McLean has extensive experience working with individuals with disabilities. She has 20 years of experiences working that includes: working in a hospital, home health agency, nursing home and a private physician's office. This includes working directly with individuals on the home and community based waiver.

The Application documents the inclusion of people with a disability or long-term illness in significant roles.

The Community Advisory Task Force will have equal membership of people with disabilities and long-term illness, providers and advocates. This task force is convened to assist the planning team with the development of this system change, will assist in awarding of all contracts, meet quarterly to review progress on system change, receive written and oral reports, and provide input on all project activities. Task Force members will also be invited to participate in the on-going evaluation of project activities and the work groups convened to assist with specific project activities. In addition, Joan Haslett, the project director for this initiative, was born with a congenital heart condition and suffers from severe arthritis. She has lived with functional limitations and has had extensive experience coordinating the health care and long-term care systems to meet the needs of her disabilities

III. Significance and Sustainability:

A. Enduring Change

Through the proposed initiative, the applicant seeks to implement enduring and effective systems of service delivery and relationships among stakeholders that will support people with a disability or long-term illness to exercise meaningful choice and control over the supports they receive and have access to community living and support that are delivered in a manner consistent with the individual's preferences.

The development of this new coordinated care organization that integrates funding and services will create a major systems change and provide an additional option for frail, vulnerable, and chronically ill elderly and physically adults. Consumers will have a choice to have their services integrated and the opportunity for early prevention that will avert or delay nursing home placement. At the center of the integration of the services will be the care management team with the consumer at the center of the team. The integration of the funding will allow consumers to

pursue more flexible service options. The integration of services will provide new quality improvement strategies for individuals to ensure that quality outcomes are balanced with the commitment to consumer choice. This combined expertise of the consumer, primary/acute care and long-term care services will result in stabilized and improved health, reduced risk of hospitalization and institutionalization, and maximized independence and ability to live the life desired by the consumer.

B. Assistance with key goals and Objectives

The applicant has a reasonable plan to:

- (a) undertake a comprehensive, system-wide reform planning process*
- (b) achieve established milestones in its comprehensive, system-wide reform planning process.*

Developing organizations that integrate funding will be a complex process requiring the consensus of State, consumers and providers. To achieve the ambitious milestones outlined will require working with many consultants. The OVHA and the DAIL have extensive experience working with contracts to achieve milestones to accomplish system changes. After the core planning team has developed a conceptual model, it is critical to work with potential providers to develop the details of the model. The key part of this plan includes providing seed money to potential organizations to assist in the planning process. In addition, all the planning will be finalized by the Community Advisory Committee. The main planning tasks include:

- Developing the model for this integrated organization
- Developing clinical and financial eligibility requirements
- Regulations & reporting requirements for state oversight

- Developing reimbursement rates
- Approval from CMS
- Developing marketing and public relations
- Developing systems for quality assurance
- Evaluation of the process

C. Sustainability

The applicant evidences that the State will anchor systems change that will endure after the grant period

The grant provides for the research and development phase of an integrated model for delivery of care that will be completed within the three year period. Ongoing support of the integrated model will come from the integration of existing funding streams. Based on each individual's need a payment from Medicaid, commercial insurance and Medicare will be developed for sustainability of the model.

A. Consumer Partnerships

There is a plan or design that details the methods the State will use to meaningfully involve individuals with a disability or long-term illness and their representative in all stage of the problem analysis, planning, implementation, monitoring and evaluation activities.

Consumers, Family members and advocacy organizations will be an integral part of all grant activities, including ongoing evaluations for continuous quality improvement.

Consumers will have an equal partnership with other stakeholders. This is the group that will make the critical decisions during the development process. They will be involved with problem analysis, planning, implementation and evaluation activities. In addition, focus groups will be held with consumers who are not committee members to provide additional feedback on the

development process. An annual forum will be held with featured speakers and workshops for education and input about the development process.

B. Public/ Private Partnerships

The OVHA will work collaboratively with the DAIL on the planning and development of this project. Numerous local service providers and other non-profit agencies and organizations including and not limited to the Assembly of Home Health Agencies, Vermont Health Care Association, Area Agencies on Aging, Vermont Center for Independent Living, The Community of Vermont Elders, Vermont Center for Disability Rights, Saint Michaels Graduate Program in Administration and Management, and Elder Services of Fletcher Allen Health Care, The Vermont Medical Society, The Vermont Association of Hospitals and Health Systems are all committed to the success of the program and will be involved on the Community Advisory Committee. In addition, during the development period the State will invite new private partners to the table. This will include the private insurers Blue Cross/Blue Shield, CIGNA healthcare, and MVP.

Use of CMS Technical Assistance

The applicant provides assurances that it will work with the identified CMS technical assistance providers to achieve the success of the proposed project.

During the first Real Choice Systems Change grant in Vermont the CMS technical assistance was critical to many successes. The technical assistance group helped with providing speakers: to two successful statewide forums; assisting with research to answer questions; and providing national contacts with other states working on the same issues. The technical assistance was provided in a wide range of expertise, including the workforce issues, developing of a paraprofessional organization, an 1115 waiver to CMS to equalize the entitlement to HCBS and

nursing homes, and developing Cash and Counseling as part of the model. For this grant the State would anticipate the same type of assistance, especially with the development of the model.

V. Budget Justification and Resources

There is a detailed budget in which budgeted costs are reasonable in relation to the proposed objectives, design and significance of achievements.

Budget Narrative

The project will be directed by Joan Haslett, M.S.A., former director of Vermont's 1st Real Choice Systems grant project. Ms. Haslett's salary will not be part of this grant as her salary is paid for by the Office of Vermont Health Access/the State Medicaid division. The grant will pay for one full time Administrative Assistant position whose salary and benefits over the 3 year period will total \$121,143.

\$32,000 is budgeted for travel to the annual CMS meetings for 2 staff from the State as well as equipment and supplies and printing costs.

\$1,425,000 is the total budgeted for consultants over the 3 year period. It is important to have professional expertise in: finance, data analysis, clinical proficiency, marketing, quality improvement and evaluation. In addition we will provide interested organizations with \$450,000 in planning money to develop integrated care organizations over the 3 year period of the grant.

\$150,000 is the budget for the community advisory task force for the 3 year period. These expenses include funds for an annual community forum for consumers as well as costs for a facilitator. This is based upon the success of the first citizens' forum held in Vermont under the first Real Choice Systems Change grant. Also, the funds will pay for a facilitator for the

community advisory task force bi-monthly meetings. The remainder will be for stipends and mileage for consumers to attend these meetings.

\$45,000 is the budget for the non-federal contribution from Graduate student assistance in the Masters of Science in Administration program at St. Michaels College in Colchester, VT. The St. Michaels graduate students are working professionals in the public/private sector and will help with the development of the business plan. In addition, the project will receive help from students in the State's Vermont Public Management Program, VPM, through the Cyprian Learning Center in Waterbury Vermont. The VPM program students will help developing the application for submittal to the Centers for Medicare and Medicaid Services.

\$75,000 is the also part of the non-federal contribution that comes from salaries, mileage, and donated room expenses at AARP. The salaries and mileage calculations come from a variety of organizations including: Vermont Center for Independent Living, Vermont Center for Disability Rights, Coalition of Vermont Elders, Area Agencies on Aging, Medical Society, Vermont Hospital and Health Systems, Vermont Assembly of Home Health Agencies, Vermont Health Care Association and AARP. All of the above organizations will contribute time and mileage to the bi-monthly meetings.

Year 1 Budget	Federal	Non-Federal	Total
Clerical asst 1FTE	\$30,000		\$30,000
Fringe (@30%)	\$9,000		\$9,000
Subtotal Salary and Benefits	\$39,000	\$30,000	\$39,000
Annual meeting 2 staff at \$2,500/mtg for airfare, per diem for meals, hotel and ground transportation	\$ 5,000		\$ 5,000
Equipment (in focus projector and computer for staff)	\$7,000		\$7,000
Subtotal travel and equipment	\$12,000		\$12,000
Con tractor – Data/IS and Finance	\$150,000		\$150,000
Contractor – Clinical	\$75,000		\$75,000
Contractor – Quality Improvement	\$75,000		\$75,000
Contractor – Marketing	\$50,000		\$50,000
Contractor – Service Delivery	\$150,000		\$150,000
Contractor - Evaluation	\$50,000		\$50,000
Subtotal – Contracts	\$550,000		\$550,000
Community advisory task force Group (travel, facilitator, etc.)	\$50,000		\$50,000
Graduate student help - St. Michaels College and Cyprian Learning Center (in-kind match)		\$15,000	
Travel and time spent on Community Advisory task force		\$25,000	
Total Direct	\$651,000		\$651,000
Total Indirect 7%	\$45,570		\$45,570
Total Non-federal match		\$40,000	
Total Budget	\$696,570		\$696,570

Year 2 Budget	Federal	Non-Federal	Total
Clerical asst 1FTE	\$31,050		\$31,050
Fringe (@30%)	\$9,315		\$9,315
Subtotal Salary and Benefits	\$40,365		\$40,365
Annual meeting 2 staff at \$2,500/mtg for airfare, per diem for meals, hotel and ground transportation	\$5,000		\$5,000
Supplies/printing	\$5,000		\$5,000
Subtotal travel and equipment and supplies	\$10,000		\$10,000
Contractor – Data/IS and Finance	\$150,000		\$150,000
Contractor – Clinical	\$75,000		\$75,000
Contractor – Quality Improvement	\$75,000		\$75,000
Contractor – Marketing	\$50,000		\$50,000
Contractor – Service Delivery	\$150,000		\$150,000
Contractor - Evaluation	\$50,000		\$50,000
Subtotal – Contracts	\$550,000		\$550,000
Community advisory task force Group (travel, facilitator, etc.)	\$50,000		\$50,000
Graduate student help - St. Michaels College and Cyprian Learning Center (in-kind match)		\$15,000	
Travel and time spent on Community Advisory task force		\$25,000	
Total Direct	\$650,365		\$650,365
Total Indirect 7%	\$45,525		\$45,525
Total Non-federal match		\$40,000	
Total Budget	\$695,891		\$695,891

Year 3 Budget	Federal	Non-Federal	Total
Clerical asst 1FTE	\$32,137		\$32,137
Fringe (@30%)	\$9,641		\$9,641
Subtotal Salary and Benefits	\$41,778		\$41,778
Annual meeting 2 staff at \$2,500/mtg for airfare, per diem for meals, hotel and ground transportation	\$ 5,000		\$ 5,000
Supplies/Printing	\$ 5,000		\$5,000
Subtotal travel, equipment & supplies	\$10,000		\$10,000
Contractor – Data/IS and Finance	\$150,000		\$150,000
Contractor – Clinical	\$75,000		\$75,000
Contractor – Quality Improvement	\$75,000		\$75,000
Contractor – Marketing	\$50,000		\$50,000
Contractor – Service Delivery	\$150,000		\$150,000
Contractor - Evaluation	\$50,000		\$50,000
Subtotal – Contracts	\$550,000		\$550,000
Community advisory task force Group (travel, facilitator, etc.)	\$50,000		\$50,000
Graduate student help - St. Michaels College and Cyprian Learning Center (in-kind match)		\$15,000	
Travel and time spent on Community Advisory task force		\$25,000	
Total Direct	\$651,778		\$651,778
Total Indirect 7%	\$45,625		\$45,625
Total Non-federal match		\$40,000	
Total Budget	\$697,403		\$697,403

Total 3 year budget	Federal	Non-Federal	Total
Clerical asst 1FTE	93,187		93,187
Fringe (@30%)	27,956		27,956
Subtotal Salary and Benefits	121,143		121,143
Annual meeting 2 staff at \$2,500/mtg for airfare, per diem for meals, hotel and ground transportation	15,000		15,000
Equipment	7,000		7,000
Supplies/printing	10,000		10,000
Subtotal travel and equipment & supplies	32,000		32,000
Contractor – Data/IS and Finance	450,000		450,000
Contractor – Clinical	225,000		225,000
Contractor – Quality Improvement	225,000		225,000
Contractor – Marketing	150,000		150,000
Contractor – Service Delivery	450,000		450,000
Contractor - Evaluation	150,000		150,000
Subtotal – Contracts	1,425,000		1,425,000
Community advisory task force Group (travel, facilitator, etc.)	150,000		150,000
Graduate student help - St. Michaels College and Cyprian Learning Center (in-kind match)		45,000	
Travel and time spent on Community Advisory task force		75,000	
Total Direct	1,953,143		1,953,143
Total Indirect 7%	136,720		136,720
Total Non-federal match		120,000	
Total Budget	2,089,863		2,089,863