

April 2008



# Vermont Choices for Care Evaluation: Roundtable Summary Final Version

**Prepared by:**

Center for Health Policy and Research  
(CHPR), Long Term Care Policy Unit in  
collaboration with the Vermont  
Department of Disabilities, Aging and  
Independent Living

**Center for Health Policy and Research**

**Project Team:**

Dee O'Connor, PhD  
Emma Quach, MPA  
Jennifer Ingle, MS, CRC

**Project Consultants:**

Christine Clements, PhD, MPH  
Judy Savageau, MPH  
Wen-Chieh Lin, PhD

**Department of Disabilities,  
Aging and Independent Living**

Adele Edelman  
Bard Hill

## Introduction

An evaluation roundtable on the Vermont Choices for Care was held January 17<sup>th</sup> and 18<sup>th</sup>, 2008 in Worcester, MA. Hosted by the University of Massachusetts Medical School's Center for Health Policy and Research (CHPR), the roundtable convened Vermont Choices for Care (CFC) implementation staff from the Department of Aging and Independent Living (DAIL), a group of nationally known long-term care experts, and evaluation staff from CHPR, the CFC external evaluator. (See Appendix 1 for a list of attendees). The purpose of the roundtable was to discuss CHPR's proposed draft evaluation plan for the CFC waiver<sup>1</sup>. The draft evaluation plan outline consists of major desired outcomes for CFC, evaluation/research questions, and methods to answer these questions. Roundtable discussions yielded a number of recommendations regarding additional data sources and suggestions regarding the analytic approaches to evaluation questions to strengthen the overall evaluation plan. See Appendix 2 for the draft evaluation plan outline presented at the roundtable.

This report provides a high-level summary of the comments and recommendations that cut across multiple evaluation questions. Specifically, we summarize recommendations, made by national experts, DAIL and other attendees, to the general approach of evaluation questions and suggestions for additional methods and data sources. Roundtable comments specific to each evaluation question are described in Appendix 3. Comments include perspectives from DAIL, CHPR, and expert attendees. This summary is meant to be a summary of the discussion at the roundtable and is intended to generate additional discussion regarding the final evaluation plan. The following recommendations are not meant to reflect CHPR's recommendations to DAIL regarding the evaluation plan at this time. Roundtable recommendations will be incorporated as appropriate after more thorough discussions between CHPR and DAIL staff. Additionally, some salient points such as costs, availability of data or business processes are recognized in this summary. Although these considerations were raised throughout the roundtable, they were not fully explored during roundtable discussions on evaluation methods. The feasibility in implementing these methods, however, will be fully explored with DAIL in finalizing the evaluation plan.

## Cross-Cutting Points

The roundtable discussion brought forth a set of evaluation ideas that cut across multiple evaluation questions in the proposed evaluation plan. These recommendations pertain to subgroup analysis, changes to data sources and methods, operationalization of key indicators, elements of formative evaluation and limitations unique to the CFC waiver.

## *Subgroups*

Because the CFC waiver was implemented statewide, there is not a naturally occurring control group to use as a comparison group for the evaluation. To partially compensate for this, roundtable attendees recommended that

---

<sup>1</sup> The evaluation plan is one of the deliverables of the contract between CHPR and DAIL

analysis of specific groups within the CFC population be conducted. These suggestions will need to be carefully considered for each evaluation question before changes are made based upon subgroup analysis. DAIL attendees of the roundtable noted that there may be some data limitations to these approaches. Suggested subgroups include:

a) *CFC Participants Rolled-Over from the Previous Waiver (vs. Participants enrolled in CFC without having enrolled in previous waiver)*  
 These two subgroups were discussed particularly with regard to quality outcomes and changes in quality of life. Separating evaluation results by these two subgroups will allow Vermont to observe whether CFC has a differential impact on roll-over subgroup versus “new” CFC participants, e.g., whether changes in quality of life indicators are associated with having received services under previous waiver as well as the CFC waiver or only having received services under CFC;

b) *Age Subgroups*  
 Analyzing results by age, i.e., non-elderly adults with disabilities and elders, was another suggestion. This may be particularly useful for analyzing the extent to which CFC participants receive the type, amount and scope of supports consistent with their assessed needs;

c) *CFC Highest, High, and Moderate Needs Groups*  
 Analyzing results by CFC level of need subgroups will be useful because these subgroups are eligible for different sets of services. At the same time, given that some moderate needs subgroup members have assessed needs similar to members of the highest/high level of need subgroups, it will be important to identify the extent to which these three subgroups are different or similar.

d) *Newly Admitted Nursing Facility Residents*  
 This subgroup could be particularly salient when analyzing results on choice and preferences of CFC participants. For instance, measuring adequacy of knowledge of options among newly admitted nursing facility residents could provide valuable information to understanding how choices regarding long-term care settings are made.

e) *Consumer or Surrogate-Directing Participants or Flexible Options*  
 These participants receive services in a different manner from those not directing their care and warrant special analytic consideration (e.g., in timeliness and access to services).

### *Data Sources*

The availability of CFC data sources and the ability to link multiple data sources, particularly data sources containing participant characteristics, will be crucial for conducting the subgroup analyses described above, to the extent

subgroup analyses are incorporated in the evaluation plan. For example, it will be important for CHPR to have participant clinical assessment data in electronic format and to link them to other data, e.g., survey results, to conduct subgroup analysis. Alternatively, participant assessment information could also be shared with ORC Macro so that they may link it to survey data and provide database de-identification. Such a linkage to participant clinical characteristics may be particularly useful when examining evaluation questions regarding access to and timeliness of CFC services. DAIL staff attending the roundtable noted that there may be some challenges in collecting/obtaining these data that would need to be discussed further.

Additional data sources were suggested regarding specific evaluation questions. For example, the Consumer Interview Tool used by DAIL's Quality Management Unit (QMU) may be a source of information on coordination of CFC service and participant satisfaction with the type, amount and scope of CFC services. In addition, QMU interviews could gather data related to participant concerns or "complaints", because current sources of complaints data may not be collected in a systematic way. Additionally, the extent to which CFC can add specific data elements to existing data collection instruments, e.g., independent living assessment, or make available other data sources, e.g., Minimum Data Set, will be critical to increasing the scope of the evaluation and its sophistication in analysis.

### *Methods*

In addition to subgroup analysis, pre/post-test analysis could be a useful method for identifying some outcomes for CFC. Specifically, pre/post data analysis could be done at some point early in the waiver and after the demonstration period to see what changes in costs occurred in order to assess cost-effectiveness of the waiver over time.

### *Key Indicators*

Clarification of key indicators to measure outcomes of interest will be important as the evaluation plan is finalized. Recommendations regarding changes to indicators that cut-across evaluation questions include:

- Distinguish outcomes measures from process measures
- Narrow the scope of the indicator and further clarify indicators
- Avoid having any indicators that measure two different concepts such as timeliness and quality of life outcome.
- Identify benchmarks and/or baselines for each indicator (where possible)
- Generate hypotheses for evaluation questions to help clarify the purpose of each indicator

### *Formative Evaluation*

Throughout the roundtable discussion, it was stressed that the CFC process evaluation merited further attention. For example, because multiple processes and variables affect outcomes of interest, e.g. participant preconceived ideas of services, settings and the effect of options counseling on

participant choice and preference for Highest and High needs groups the inclusion of process measures will assist CFC to improve their waiver processes and conduct continuous improvement. In addition, adding process evaluation measures to the plan would be informative to others states interested in replicating the CFC model or modifying their own applications of the programs' components.

A process evaluation serves to capture changes in implementation of the waiver over time and whether or not the waiver was implemented as planned. Adding process evaluation measures to the plan could inform DAIL about possible changes to implementation of the waiver.

## **Conclusion**

The participation of Vermont staff, national long-term care experts, and CHPR researchers in the evaluation roundtable yielded a number of valuable ideas for planning a rigorous and sound evaluation. This summary document aimed to capture both broad and more specific comments relating to CFC evaluation planning. We anticipate that the ideas from the roundtable will assist CHPR and Vermont staff at DAIL and DCF to strengthen the evaluation plan and inform evaluators in the course of executing the evaluation.

## Appendix 1

### Vermont Choices for Care Evaluation Roundtable Attendee List

#### National Experts

**Brian Burwell** is Vice President for Chronic Care and Disability at Thompson Healthcare (formerly Thomson/MEDSTAT)

**Dan Gilden** is President & CEO of Jen Associates, Incorporated (JAI).

**Lenny Gruenberg, Ph.D.** is a private consultant and President of the Long-Term Care Data Institute.

**Cindy Gruman, Ph.D.**, is a senior researcher for Mathematica Policy Research.

**Walter Leutz, Ph.D.**, is Associate Professor at Brandeis University's Heller School for Social Policy and Management.

**Hunter McKay** is a Project Officer at the US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy (DALTC).

**Kevin Mahoney, Ph.D.**, is Professor at the Boston College Graduate School of Social Work.

#### Vermont Department of Aging and Independent Living (DAIL)

**Adele Edelman**, Waiver Manager, Division of Disability and Aging Services (DAIL)

**Joe Carlomagno**, Director, Quality Management Unit, DAIL

**Fran Keeler**, Director, Division of Licensing and Protection, DAIL

**Lorraine Wargo**, Director, Individual Supports Unit, DAIL

**Theresa Wood**, Deputy Commissioner, DAIL

**Dale Brooks**, System Developer, Information and Data Unit, DAIL,

**Dick Lavery**, Senior Planner, Information and Data Unit, DAIL,

**Megan Tierney-Ward**, Waiver Supervisor, Individual Supports Unit, DAIL

#### Invitee

**Joan Senecal**, Commissioner, DAIL

#### Vermont Advocacy Community

**Dolly Fleming**, Vermont Coalition of Vermont Elders

**Debra Lisi-Baker**, Executive Director, Vermont Center for Independent Living

#### University of Vermont (Evaluation Subcontractor to CHPR)

**Cheryl Mitchell, Ph.D.**, Research Professor, Vermont Research Partnership

## **UMMS/CHPR**

### *Evaluation Team*

**Dee O'Connor, Ph.D.**, Associate Professor and Director, Long-Term Care Policy, Principle Investigator for Vermont Choices for Care Evaluation

**Emma Quach, MPA**, Project Director for Vermont Choices for Care Evaluation

**Christine Clements, Ph.D.**, Assistant Professor, Associate Director, Evaluation Unit

**Jennifer Ingle, MS, CRC**, Project Associate

**Wen-Chieh Lin, Ph.D.**, Assistant Professor

**Judy Savageau, MPH**, Assistant Professor

### *Additional UMMS/CHPR Discussants*

**Laney Bruner-Canhoto, Ph.D.**, Project Director Lead for Massachusetts Systems Transformation Grant Evaluation

**Robin Clark, Ph.D.**, Deputy Director Center for Health Policy and Research

**Nicole Lomerson, MPH**, Project Associate Project staff for Maine Systems Transformation Evaluation

**Rick McManus, MPP, MSW**, Senior Project Director and Lead for Maine Systems Transformation Evaluation

**Ron Steingard, MD**, Director, Center for Health Policy and Research, Associate Vice Chancellor and Chief Medical Officer, Commonwealth Medicine

## Appendix 2

### Key Indicators and Data Sources from CFC Evaluation Plan Outline

#### Participant Knowledge

*1. To what extent are participants' expressed preferences regarding services, self-direction, and setting incorporated in service assessment and planning?*

Key Indicators	Data Sources
1) Increase in the % in participants reporting they had enough input when planning for their services	Descriptive statistics from Macro Annual Vermont Consumer Survey (referred to as the consumer survey here after)
2) Increase in the % of participants reporting that they were involved in making decisions about their help they would receive upon hospital discharge	Descriptive statistics from Macro Annual Vermont Consumer Survey
3) Increase in the % of participants and family members who report that their case managers were responsive to their preferences on setting and service type and caregiver type	Annual interviews with participants, family members, providers, and stakeholders
4) Participants report that they received information and were involved in decision-making regarding daily activities upon hospital discharge	Annual interviews with participants and family members
5) % of nursing home residents reporting their preferences were supported	Annual interviews with participants and family members

#### Participant Choice of and Access to Services

*2a. Are new CFC participants or NF residents who seek discharge able to receive CFC community services in a timely manner?*

Key Indicators	Data Sources
1) Decline in percent of "pending applications" of the total received applications	Service application, eligibility determination data in SAMS
2) Decline in average days: <ul style="list-style-type: none"> <li>• clinical and financial eligibility determination</li> <li>• service authorization/Hospital/NF discharge/to service initiation</li> </ul>	SAMS—data elements to be determined
3) Increase in participants reporting services are timely	Consumer survey
4) Decrease in participants reporting specific access barriers	Interviews with participants, family members, and stakeholders

*2b. To what extent are CFC participants receiving the types and amount of supports consistent with their assessed needs?*

<b>Key Indicators</b>	<b>Data Sources</b>
1) Increase in number of cases with service types consistent with assessed needs	Record reviews for a sample of participants in the community or record reviews drawn from reviews from QMU
2) Ratio of average authorized service units to average delivered service units for each major service type	SAMS and Claims Data
3) Participants, family members, providers and stakeholders report that the level of help participants receive, including that to self-direct their services, is adequate or has increased	Interviews
4) Decrease in number of CFC participants' complaints regarding adequacy of the amount or type of CFC supports	Ombudsman complaints data

**Quality of Care – Short Term Outcomes**

*3a. To what extent are participants' long-term care supports coordinated with each other to provide effective care to participants?*

<b>Key Indicators</b>	<b>Data Sources</b>
1) Increase in the # of participants and key informants who report that effectiveness in coordination among staff has increased	Interviews with participants' family members, providers and other key informants
2) Increase in the # of participants whose CFC HCBS providers use the same service plan	Case reviews for a sample of participants

*3b. Is the Choices for Care wavier increasing in its ability to serve participants of all levels of need in the community?*

<b>Key Indicators</b>	<b>Data Sources</b>
1) Increase in % of CFC participants living in the community by LON	Enrollment, eligibility, and residential location data in SAMS
2) Increase in % of participants reporting the "degree to which their services meet their needs"	Consumer survey and interviews
3) Decrease in average # of unmet needs	Assessment data
4) Increase in % of moderate needs participants reporting that their services meet their needs	Interviews with participants

3c. *To what extent did Medicaid nursing facility residents' acuity, as measured by physical and cognitive performance, change over the demonstration period?*

Key Indicators	Data Sources
1) Increase in physical and cognitive performance scores* for nursing home residents	MDS data for select years
2) Reduction in the % of CFC residents in nursing homes receiving assistance with fewer than 2 ADL needs	MDS data for select years, starting with 2003, for which available data exists

**Participant Satisfaction**

4. *To what extent are CFC participants experiencing higher satisfaction with types, amount, and scope of CFC services?*

Key Indicators	Data Sources
1) Reduction in # of complaints regarding CFC services by setting	CFC Complaints data regarding CFC services
2) Increase in % of participants reporting they are satisfied with CFC service timeliness and quality	Consumer survey

**Participant Quality of Life**

5. *To what extent did CFC participants' quality of life improve over the demonstration period?*

Key Indicators	Data Sources
1) Increase in the % of participants who report an increase in quality of life	Consumer Survey
2) Increase in the % of participants who report they spend their free time the way they want	Consumer Survey
3) Caregiver quality of life increases with increased respite services	Interviews with caregivers

**Quality of Care – Long Term Outcome**

6. *To what extent are CFC participants' medical and long-term care needs being effectively addressed?*

Key Indicators	Data Sources
1) Increase in the % of participants reporting their LTC needs are adequately addressed	Consumer Survey

2) Increase in the % of participants whose rating of their general health is “good” or better	Consumer Survey
3) Increase in the % of participants whose rating of their quality of life is “good” or better	Consumer Survey
4) Decrease in long-term NF admissions	Medicare/Medicaid claims/diagnosis data
5) Decline in hospitalization rate for specified ambulatory care sensitive conditions	Medicare/Medicaid claims/diagnosis

### Waiver Cost-Effectiveness and System-Wide Rebalancing

7. *Were the average annual costs of serving CFC participants less than or equal to the projected annual costs for serving this population in the absence of the waiver?*

Key Indicators	Data Sources
1) Actual annual Medicaid expenditures ≤ Projected costs	Project costs claims data
2) Decrease in annual percent of Medicaid expenditures incurred for NF	Medicaid claims data
3) Average annual Medicaid expenditures for each enrollment group (highest, high, moderate)	Medicaid claims data

## Appendix 3

### Roundtable Sessions' Comments and Recommendations

The following comments from the roundtable are broken down by each evaluation question. For each question comments are categorized as either

- 1) Issues to consider for implementation and consideration for the formative evaluation
- 2) Feedback regarding the analytical approach to the question
- 3) Additional independent variables to consider regarding the question and
- 4) Recommendations regarding specific indicators (e.g. changes to language, additional indicators to consider or deletion of indicators)

#### ***Session A: Participant Knowledge of LTC Supports and Settings***

##### Evaluation Question

1. To what extent are participants' expressed preferences regarding services, self-direction and setting incorporated in service assessment and planning?

##### *Implementation Issues/Ideas for Formative Evaluation*

- Process of options counseling may warrant further examination, e.g., amount of information during options counseling, time devoted to options counseling may be limited due to staffing, role of LTCCC and case manager.
- Closing of NF beds and enhanced residential care (ERC) waitlists limits choices of settings
- Provider and participant preconceived notions on LTC settings play a role in how preferences for setting are expressed and incorporated.

##### *Additional Independent Variables*

- Case managers' relationship with the CFC participant
- Doctor's attitudes towards community settings may affect participant preferences
- CFC applicants' existing knowledge of services, settings and supports will, in turn, affect their perception of whether their preferences are met.

##### *Indicator-Specific Recommendations*

- Another indicator may be whether participants feel that the amount of information they receive was adequate to help them make their choices about services and settings.

#### **Session B: Participant Choice of and Access to Services**

##### Evaluation Questions

2a. Are new CFC participants or NF residents who seek discharge able to receive CFC community services in a timely manner?

2b. To what extent are CFC participants receiving the types and amount of supports consistent with their assessed needs?

*Additional Independent Variables on Service Access/Timeliness*

- Participants with SSI experience a faster financial eligibility determination process. New CFC participants versus existing participants (in previous waiver) have different financial eligibility processes. These subgroups may need to be examined.
- Local/regional supply of service providers, the number of days spent in NFs or hospitals, and the degree of family assistance are also likely to affect service access.

*Implementation Issues/Ideas for Formative Evaluation*

- Low enrollment in Flexible Choices raises questions as to whether participants have access to this service option. There may be attitudinal barriers of providers regarding Flexible Choices and other services or service settings.
- Any consideration of changes to expedite eligibility determination will need to recognize that some changes, e.g., Medicaid financial rules, are more difficult than others, e.g., clinical eligibility process, because the former would require amendments to the waiver, whereas the latter may require changes to business process/program procedures.
- Changes in “assessed needs” may be due to different case managers’ assessments and philosophies.
- To understand timeliness of HCBS, one could inquire some segment of the NF population, e.g., newly admitted residents, regarding their experience with accessing HCBS prior to NF admissions.
- Looking at individuals with low case mix score may be one way of targeting individuals who are likely to transition to a community setting.
- Some people’s needs change quickly between assessments. It is important to put services in place quickly.

*Feedback on Evaluation Plan Questions and Approach*

- Track time between different “status” points. For example, from clinical assessment to financial eligibility determination

*Indicator Specific Recommendations*

- Take out the first indicator (“Decline in the percentage of “pending applications” of the total received applications”) in question 2a.

**Session C: Quality of Care – Short Term Outcomes**

Evaluation Questions

- 3a. To what extent are participants' long-term care supports coordinated with each other to provide effective care to participants?
- 3b. Is the Choices for Care waiver increasing in its ability to serve participants of all levels of need in the community?
- 3c. To what extent did Medicaid nursing facility residents' acuity, as measured by physical and cognitive performance, change over the demonstration period?

#### *Implementation Issues/Ideas for Formative Evaluation*

- How will QMU promote enthusiasm for quality of care and quality of life issues as part of their reviews and technical assistance activities with provider agencies. (3a, 3b, 3c)
- Look at waiver team meetings as a source of coordination between providers (3a)

#### *Feedback on Evaluation Plan Questions and Approach*

- Clarify the hypotheses related to question 3c by setting up a hypothesis matrix with each indicator and look at ways to do sub-group analysis. The expectation here might be that both the HCBS and NF folks both become frailer as the demonstration goes forward.
- Subgroup analysis could be done with those coming from hospitals to CFC and could be a naturally occurring subgroup for analysis. Look for changes in acuity levels over life of the evaluation.
- Consider use of the Consumer Interview Tool (QMU) along with other data sources (ie ORC Macro survey) as a data source for question 3b
- Data sources to look at may be HEDIS measures, Zimmerman quality measures of quality of care, MDS data for ADL levels and how quality of care differs depending on participants' ADL needs or their need for supports

#### *Indicator-Specific Recommendations (See Appendix 2 for list of indicators)*

- Operationalization of "coordination" for interviews for key indicator #1 for 3a
- How will communication among service providers be turned into an indicator of coordination?
- Indicator #2 in 3b will be moved to 3a. The indicator is: "Increase in the % of participants reporting "the degree to which their services meet their needs"
- In indicator #2 for question 3a, "Increase in the # of participants whose CFC HCBS providers use of the same service plan" needs clarification in terms of exactly what using the same service plan means.
- Indicator #3 in question 3b which reads "Increase in participants whose service plan includes services that address their unmet needs" data on unmet needs may not analyzable.
- In indicator #2 in 3c, "cognitive needs" could be added in an effort to capture cueing that occurs in nursing facilities.

## Session C: Participant Satisfaction

### Evaluation Question

4. To what extent are CFC participants experiencing higher satisfaction with types, amount, and scope of CFC services?

#### *Feedback on Evaluation Plan Questions and Approach*

- Complaints data (data source for indicator 1) can be difficult to capture and not all complaints may be captured in logs. Using interviews to supplement complaint log data is recommended.
- Consider subgroup analysis and linking subgroups to satisfaction and ADL acuity levels (ie from assessments)
- Preempt survey fatigue for participants by administering questions with DAIL existing surveys
- Self-report of service satisfaction is often exaggerated.

#### *Indicator-Specific Recommendations*

- For indicator #1 (Reduction in # of complaints regarding CFC services by setting ) “reduction” may not be the best indicator because the HCBS Ombudsmen works to resolve complaints. A better measure might be the # of complaints resolved or a qualitative analysis of the kinds of complaints addressed.
- For indicator #2 (Increase in % of participants reporting they are satisfied with CFC service timeliness and quality) separate the concept of timeliness of the delivery of services and quality and measure them distinctly.

## Session C: Participant Quality of Life

### Evaluation Question

5. To what extent did CFC participants’ quality of life improve over the demonstration period?

#### *Feedback on Evaluation Plan Questions and Approach*

- Basing the CHPR evaluation for quality more on the principles of the QMU plan may be effective when measuring quality of life. There was a realization that QMU focuses on how Vermont is evaluating their providers and that the information collected can be analyzed for CHPR’s evaluation as well.
- Do not lose sight of Vermont’s waiver philosophy to serve participants in the setting of their choice. Measuring outcomes in both nursing facilities and home care settings would capture both setting choices.
- Separate effectiveness measures from quality of life measures
- Consider time of NF entry to the time of HCBS entry when looking at quality improvements as there may be a dose response type of effect where quality measures go up after NF discharge into HCBS.

*Indicator-Specific Recommendations*

- An alternative to measuring respite as an indicator of family member satisfaction may be caregiver burden. Other measures should be considered as family member interview guide is developed.
- Examine professional caregivers (i.e. adult day) as part of indicator (#3) or as a separate indicator. A data source of focus groups with caregivers (professional and informal) could be added to this indicator.

**Session D: Quality of Care – Long Term Outcome**Evaluation Question

6. To what extent are CFC participants' medical and long-term care needs being effectively addressed?

*Implementation Issues/Ideas for Formative Evaluation*

- Consider looking at integrated care models (PACE and MYCARE)
- Telemedicine efforts may have an effect on quality of care issues, in case Vermont implements this.
- A decrease in NF admissions over time will require a more robust HCBS system (cross-cutting)
- Consider the capacity of the system to look at preventable conditions to impact hospitalization (However, it was not clear whether CFC could be expected to affect this).

*Feedback on Evaluation Plan Questions and Approach*

- Look at costs savings at an aggregate level for the whole CFC system (the meaning of 'whole system' was not further defined at the time of the roundtable)
- PACE participants in CFC may be another group to look at where some changes in hospitalizations as a measure of how CFC is meeting the needs of participants.

*Additional Independent Variables Effecting LTC Needs Being Met*

- A falls prevention program in Vermont may have some effect on the measurement of this question (particularly indicator #5) and should not be attributed to CFC. Vermont has a high rate of falls and may lead to hospitalizations. Also reporting of falls in Vermont may be more prevalent than in other states due to this program. Many other variables, as well...
- Some members accessing services through Independent Living Center's (ILCs) cannot receive all their services because their resources are already committed (ie. lack of service providers)
- Vermont's NF diversion grant (not in CFC) may affect some of these measures as they are looking at options counseling for people and planning for LTC needs.

- Other variables such as transportation, linkages with services, medication management and communication between the health care system and LTC systems could all affect the measurement of this outcome.

#### *Indicator-Specific Recommendations*

- A possible process indicator is the number of service hours participants are receiving.
- Case findings from the data that initially show an increase in hospitalizations of CFC participants may be due to undiagnosed or untreated conditions prior to enrollment in CFC. It is important to keep this in mind when reviewing hospitalization data of CFC participants.
- In indicator # 4, a better measure may be to look at length of NF stays instead of the number of long-term NF admissions.
- Suggestion for indicator #4 would be to create taxonomy of NF stays. Three groups might be 1) extended rehabilitation group 2) end-of-life care group and 3) long-term NF stays. Over the course of the waiver, we may see more rehabilitation stays and less use of long-term NF care.
- For indicator #5, a suggestion was to look a specific diagnosis and create hypotheses based on diagnoses (i.e. hip fractures).

### **Session E: Waiver Cost-Effectiveness and System-Wide Rebalancing**

#### Evaluation Question

7. Were the average annual costs of serving CFC participants less than or equal to the projected annual costs for serving this population in the absence of the waiver?

#### *Implementation Issues/Ideas for Formative Evaluation*

- Vermont's expectation is to serve more people in HCBS but they are unsure of the number of NF beds to protect. The balance between the number of available nursing facility slots and the number of HCBS slots will be important over time.
- Concern that the 'savings' from the waiver is not going back into services to sustain the waiver and serving people in HCBS

#### *Feedback on Evaluation Plan Questions and Approach*

- Consider costs of persons with physical disabilities versus those with cognitive disabilities and mental illness. HCFA-64 contains some of these data.
- Measure cost-effectiveness in various ways. Suggestions are to do a pre-post analysis (although difficult in this case) and compare Vermont to other states.
- Explore how NF utilization changed over the course of the waiver and changes in the demographics of the waiver population over the course of the demonstration.

- Examine number and percentage of NF admissions coming from the community versus those coming from hospitals.
- Need general trajectory of cost data by level of need
- Individual beneficiary data versus interrupted time series
- Need standard database to track key items of utilization and cost over time. Need linkages between acute care data systems (hospitals, short term NF stays) and community-based care data systems
- Constructing a timeline of major CFC events/policy changes will provide context for changes in expenditures.

*Indicator-Specific Recommendations (See Appendix 2 for list of indicators)*

- For indicator #3 it was suggested to compare pre-waiver population to now (as there was no moderate needs group prior to the waiver).

## **Session F: Waitlist Population Discussion**

DAIL staff attending the roundtable informed the group that a waitlist will be reinstated starting February 2008. Recognizing that this group could serve as a comparison group to those already receiving waiver services, the group decided to discuss the potential for analysis using the waitlisted group instead of discussing long-term care public awareness, which was originally scheduled. The following are some of the main points from this discussion.

*DAIL Information about the Waitlist/Other Variables*

- The waitlist will be instituted in February 2008 due to lack of sufficient resources to maintain services for some who qualify for CFC. The CFC waiver needs to stay within its budget allocations.
- Waitlisted applicants will be reviewed continuously by the waiver teams. The waitlist is projected to be in place for 18 months, based on current information about the budget. It is expected that a small number of applicants will come off the waitlist over time because their needs increase or they have 'special circumstances'.
- Challenges regarding the waitlist include:
  - 1) Case management services for participants on the waitlist are not reimbursable under the waiver.
  - 2) The waitlist may erode public confidence in the waiver.
  - 3) Not serving the moderate needs group in order to avoid a waitlist for high needs applicants will not be possible. CFC will need to maintain the moderate needs group under the regulations of the waiver. Some high needs individuals may seek services under the moderate needs program while they are waiting for enrollment in the high need category.
  - 4) Vermont is attempting to apply special circumstances as equally as possible during waitlist time frame in order to avoid a bias toward institutionalization.

### *Implementation Issues/Ideas for Formative Evaluation*

- Vermont is moving to create more options for services under the moderate needs group category. CHPR suggested that they consider phasing in any changes to services for the moderate needs group (e.g., access to Flexible Choices) by region in order to assure a smooth transition.
- Examine the moderate needs groups' services closely and what happens when their needs change over time.
- Measure the stress on caregivers and other supports for those on the waitlist. Some examples of variables to measure might be employment status, health insurance situation, dissolutions of marriage and increases in mortality risk.
- The moderate needs group may be a natural comparison group to high need group participants on the waitlist. Further exploration of the factors leading to CFC high needs participants on the waitlist.

### *Recommendations for Comparison of Waitlisted Participants with other CFC Participants*

- Moderate needs group is a natural comparison group whose experiences may serve as a basis for comparison for those with high needs who may be on the new waitlist. If there is an expansion of the services under the moderate needs group, those in the high need group may look more similar to the moderate needs group over time.
- Gather more information regarding non-CFC services that people receive while on the waitlist, for example, what informal and family supports do people receive?
- Compare assessed needs at the time of application and at the time a person comes off the waitlist and note the services people have received in between assessments as well.
- Examine the trajectory of people on waitlist over time. For example, how many had a change in level of need or health status before getting off the waitlist and into CFC services. Results of these participants could be compared to those not put on the waitlist.
- Consider case mix stratification for moderate needs group.
- Track rates of "preventable" hospitalizations for individuals on the waiting list.

For more information, please  
contact Jennifer Ingle at (508)  
856-7581



333 South Street, Shrewsbury, MA 01545-2732  
Tel. (508) 856-7857 Fax. (508) 856-8543  
[www.umassmed.edu/healthpolicy](http://www.umassmed.edu/healthpolicy) [healthpolicy@umassmed.edu](mailto:healthpolicy@umassmed.edu)