

Vermont Choices for Care Evaluation Results 2005-2008

UMMS Presentation to DAIL Advisory Board September 2009

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Overview of Presentation

I. Purpose

II. Evaluation Framework

III. Major CFC Developments

IV. Highlights from Policy Reviews

V. Findings and Recommendations by
Individual Desired Outcome

VI. Concluding Remarks

Purpose

- Describe scope of UMMS evaluation work to date
- Review goals and desired outcomes of CFC
- Describe major CFC developments in 2005-2008
- Highlight findings from CFC policy and evaluations reviews for the October 2005-2008 period
- Make recommendations emerging from 2005-2008 data
- Solicit feedback/ideas from Advisory Board members on findings and recommendations

Scope of UMMS Work on CFC to Date

- UMMS refined CFC goals into a set of desired outcomes that are feasible, actionable, and measurable.
- UMMS conducted policy reviews and evaluations to understand whether and how CFC has met these outcomes.
- Focus of policy reviews and evaluation studies was based on Vermont priorities & available resources.

Evaluation Framework

1. Information to Choose Long-Term Care Setting
 - *Choice of Setting/Supports*
2. Timely Access
3. Effectiveness (Ability to Live Longer in Community)
 - *Serve more people*
 - *Create a balanced system of LTC by increasing the capacity of the HCBS system, while maintaining the right number of quality nursing facility beds*
 - *Prepare for future population growth*
4. Positive Experiences with Care
 - *Ensure quality, and expand quality improvement activities*

Note: italics denote DAIL's language on CFC goals

Evaluation Framework (cont.)

5. Improved Self-Reported Quality of Life
6. Equal Application of Applicants List (to HCBS and NF settings)
 - *Equal Access*
7. Budget Neutrality
 - *Manage the costs of long-term care*
8. Public Awareness of Long-Term Care Setting Options
9. Positive Long-Term Care and Health Outcomes

Note: italics denote DAIL's language on CFC goals

Evaluation Framework: Analyses to Date

- 2006-2007: Conducted semi-structured interviews with Choices for Care state staff, advocates, provider staff, consumers, & family members; focus groups with provider staff & consumers
- Analyzed CFC eligibility, applicants list, and quality management policies and procedures (Policy Briefs)
- Analyzed 3 MACRO consumer satisfaction surveys (2006-2008), 2008 MACRO survey merged with 2008 assessment & service authorization data
- Reviewed DAIL CFC Quarterly Oct.2005-2008 Reports & Reports to CMS

Major CFC Developments

- Three major CFC community-based options were developed: PACE, Flexible Choices, 24-hour care, and Spousal Caregiver Payments.
- Moderate needs group applicants apply with a case management agency, as of April 2008, instead of with an adult day or homemaker agency.
- Quality management reviews of some CFC HCBS providers have been suspended, pending examination of a more efficient method for HCBS providers across DAIL programs.

HIGHLIGHTS: CFC POLICY REVIEWS

2008: CFC Eligibility

- CFC financial eligibility policy expedites & facilitates process for HCBS applicants by:
 - a) eliminating the look-back period for very low-income applicants
 - b) taking into account medical expenses in calculating income; and
 - c) excluding the requirement that a lien be placed at time of HCBS application
- CFC clinical eligibility policy allows for up to 30 days for clinical determination.
- DAIL has begun collecting more data on key dates to measure timeliness of eligibility determination.

Eligibility Recommendation

- There is cost to the state associated with presumptive financial eligibility and expediting clinical eligibility.
- DAIL should periodically weigh the potential costs and benefits of implementing presumptive financial eligibility and expediting clinical eligibility by allowing clinical determination via telephone.

2008: Quality Monitoring of CFC Providers

- CFC providers (HCBS, ERCs, and nursing facilities) are periodically reviewed using different guidelines.
- Licensing and review data reside with Division of Licensing and Protection and Division of Aging and Disability Services.
- Some CFC providers, such as home health agencies, may be reviewed several times by Vermont but, little data exists on independent providers.

QA Recommendations:

- Focusing reviews on case management agencies can reduce burden of reviewing every single HCBS provider.
- ERC and NF licensure requirements could be improved by more person-centered outcomes.
- Ensure adequate monitoring of independent providers (whether by consumer employers or other entities).

FINDINGS BY DESIRED OUTCOME

1. Information to Choose LTC Setting

- Primary means of CFC provision of information to consumers and providers is the long-term care clinical coordinators (LTCCCs).
- In year 2, stakeholders, providers, and consumers alike reported having little knowledge of new options such as Flexible Choices.
- Recent (March 2008) “CFC 101” training and at least one “Flexible Choices fair” in one county (2007) were held.

1. Information Dissemination

Indicators from MACRO surveys	Year 1 (10/05-9/06)	Year 2 (10/06-9/07)	Year 3 (10/07-9/08)
A. "Choice and control when planning for their services"	86%	91% ¹	89%
A1. Older (85+)/oldest (65-85) > younger (18-64)*			91% v. 84%
A2. AAA Case Management (CM) > HHA CM			93% v. 87%
B. "People listen to [their] needs and preferences"	89%	92% ¹	93%¹
B1. Older/oldest > young age group			97/96% v. 84%
B2. High > moderate needs			97% v. 90%
B3. Female > Male			94% v. 90%
B4. Self-directed > Agency-Directed			96% v. 90%

• > Denotes that the participant subgroup (s) preceding the ">" symbol had significantly higher satisfaction rate (only in Year 3) than the subgroup(s) following in this symbol

¹ = indicates statistical different from 2006 (year 1)

1. Information Dissemination: Recommendation

Re-allocate time and resources to strengthen options education to participants (particularly when participants change setting of care) and outreach to providers to convey efficacy of HCBS.

2. Timely Access

- LTCCCs conduct clinical eligibility determination for Highest/High; case managers for Moderate Needs (formerly conducted by adult day/homemaker agencies); Dept of Children and Family conduct financial eligibility determination.
- Applications to CFC have increased from year 1; average monthly number of new applications to CFC each year during the 2005-2008 period were 244, 355, and 352 respectively.

2. Timely Access (cont.)

- In year 2, key informants reported that clinical eligibility determination generally was timely (<1 week), but financial eligibility determination was time-consuming and confusing for applicants and/or family members.
- In Year 3, differences were founded in satisfaction rates with “timeliness”:
 - older (65-85) participants’ exceeded that of younger ones (18-64); and
 - self-directing (consumer-direction, surrogate-direction, Flexible Choices) participants’ exceeded that of agency-directing.

2. Timely Access (cont.)

Indicators from MACRO surveys	Year 1	Year 2	Year 3
<i>C. "Timely services"</i>	84%	91% ¹	89% ¹
C1. Older and oldest > younger *			90/91% v. 83%
C2. Self-directed > agency-directed services			92% v. 87%
<i>D. "Services Fit Schedule"</i>	86%	90% ¹	90% ¹
D1. Older > younger age group			95/91% v. 86%
D2. High/Highest > moderate Needs			95/92% v. 87%
D3. Self-directed > agency-directed services			95% v. 88%

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2. Timely Access: Recommendation

- Periodically assess costs and benefits of mechanisms to expedite eligibility determination process
- Consider adopting other states' practices of requiring dates of service in HCBS claims submissions

3. Effectiveness

(Ability to Live in Community Longer)

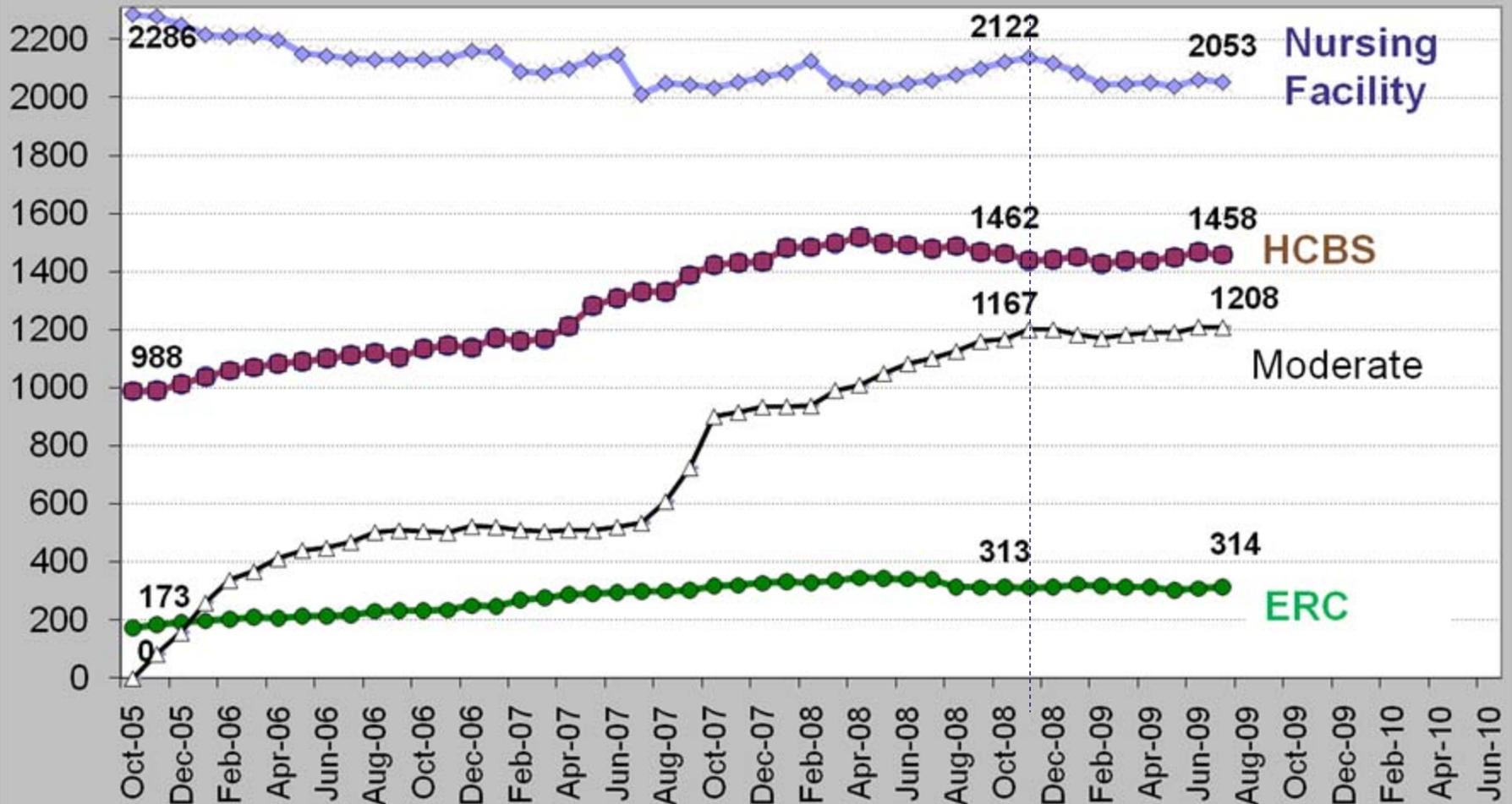
- Total enrollment increased each year during 2005-2008.
- Nursing facilities was the setting with the largest enrollment in each year (66% in Oct 2005, 42% in Oct 2008).
- However, HCBS, ERC, and Moderate Needs enrollment trend was upward while NF enrollment trend was slightly downward during 2005-2008.
- During second half of FY2008, ERC and HCBS enrollment gradually fell while NF enrollment slightly climbed.

3. Effectiveness (cont.)

- CFC served more highest needs clients each year than any other level of need.
- Although most highest needs participants were in nursing facilities (71% in 2005 and 60% in 2008), the percent of highest needs clients in HCBS and ERC settings of all highest needs clients increased.

3. Effectiveness (cont.)

Choices for Care: Total Number of Enrolled Participants by Setting
October 2005 - July 2009



3. Effectiveness (cont.)

- Year 2 interviewees cited the need for more supports for persons with cueing/supervision needs
- In Year 3, self-directing clients reported higher satisfaction with outcomes, e.g., “services meet needs” in 2008 compared to agency-directed clients.

3. Effectiveness (cont.)

Indicators from MACRO surveys	Year 1	Year 2	Year 3
E. "Services Meet Needs"	89%	91% ¹	91%
E1. High/Highest > moderate Needs			97/96% v. 86%
E2. Intensive > Low ADL Needs			97% v. 89%
E3. Self-Directed > Agency-Directed			96% v. 89%
F. "Help Made Life Better"	95%	96%	92%^{1,2}
F1. High > moderate Needs			96% v. 89%
F2. Medium > Low ADL Needs			96% v. 90%
F3. Self-Directed > Agency-Directed			95% v. 90%
F4. AAA > HHA CM			95% v. 89%

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¹ = indicates statistical different from 2006 (year 1)

² = indicates statistical different from 2007 (year 2)

3. Effectiveness: Recommendations

- Ensure adequate cueing/supervision supports are available in HCBS settings
- Make self-direction available to more participants
- Use transition services to further reduce NF use.

4. Experiences with Care

- In all three years, courtesy of HCBS caregivers was consistently rated as good/excellent (98% in 2008).
- “Good/excellent quality of services” was reported by 93% of HCBS participants
- In 2008, Vermont nursing facility residents reported high satisfaction with multiple service quality measures.
- Moderate needs study pointed out several factors affecting moderate needs participant satisfaction: available hours, lack of service flexibility, and quality of work performed by providers.

4. Experiences with Care (cont.)

Indicators from MACRO surveys	Year 1 (10/05-9/06)	Year 2 (10/06-9/07)	Year 3 (10/07-9/08)
G. <i>"Courtesy of Others"</i>	97%	98% ¹	98%
E1. Oldest > Younger			100% v. 97%
H. <i>"Quality of Services"</i>	92%	94% ¹	98%
F1. Highest/High > moderate Needs			100/97% v. 88%
F2. Medium/Intensive > Low ADL Needs			97% v. 91%
F3. Self-Directed > Agency-Directed			97% v. 90%

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4. Experiences with Care: Recommendation

Because data on ERC residents experiences with care is lacking, DAIL should evaluate ERC participant experiences with care.

5. Self-Reported Quality of Life

- Overall “quality of life” was reported as good or excellent by 63%, 71%, and 70% of HCBS participants in years 1-3 respectively.
- Stakeholders reported in year 2 interviews a desire for more community-based social supports, e.g., companion, non-medical transportation.
- In Year 3, HCBS participants reported being satisfied at the following rates on 3 specific quality of life indicators:
 - “get around inside home”--78% of HCBS participants reported they were satisfied
 - “how one spent free time”--67% “ “
 - “social lives and connections to the community”--55% “ “

5. Self-Reported Quality of Life (cont.)

Indicators from MACRO surveys	Year 1	Year 2	Year 3
I. "Overall Quality of Life" compared to those your age	63%	71% ¹	70% ¹
I1. Older/oldest > younger participants			80/74% v. 57%
I2. Female > Male			73% v. 64%
J. "How I Spend My Free Time"	63%	64%	67%
J1. Female > Male			69% v. 61%
J2. Older > younger			70% v. 60%
K. "Get Around Inside Home As Much As Need To"	75%	80% ¹	78%
K1. Low > Medium/Intensive ADL Needs			83% v. 75/64%
K2. Moderate > Highest Level of Need			82% v. 74%
L. "Social Life and my connection to my community"	55%	54%	55%

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5. Self-Reported Quality of Life: Recommendation

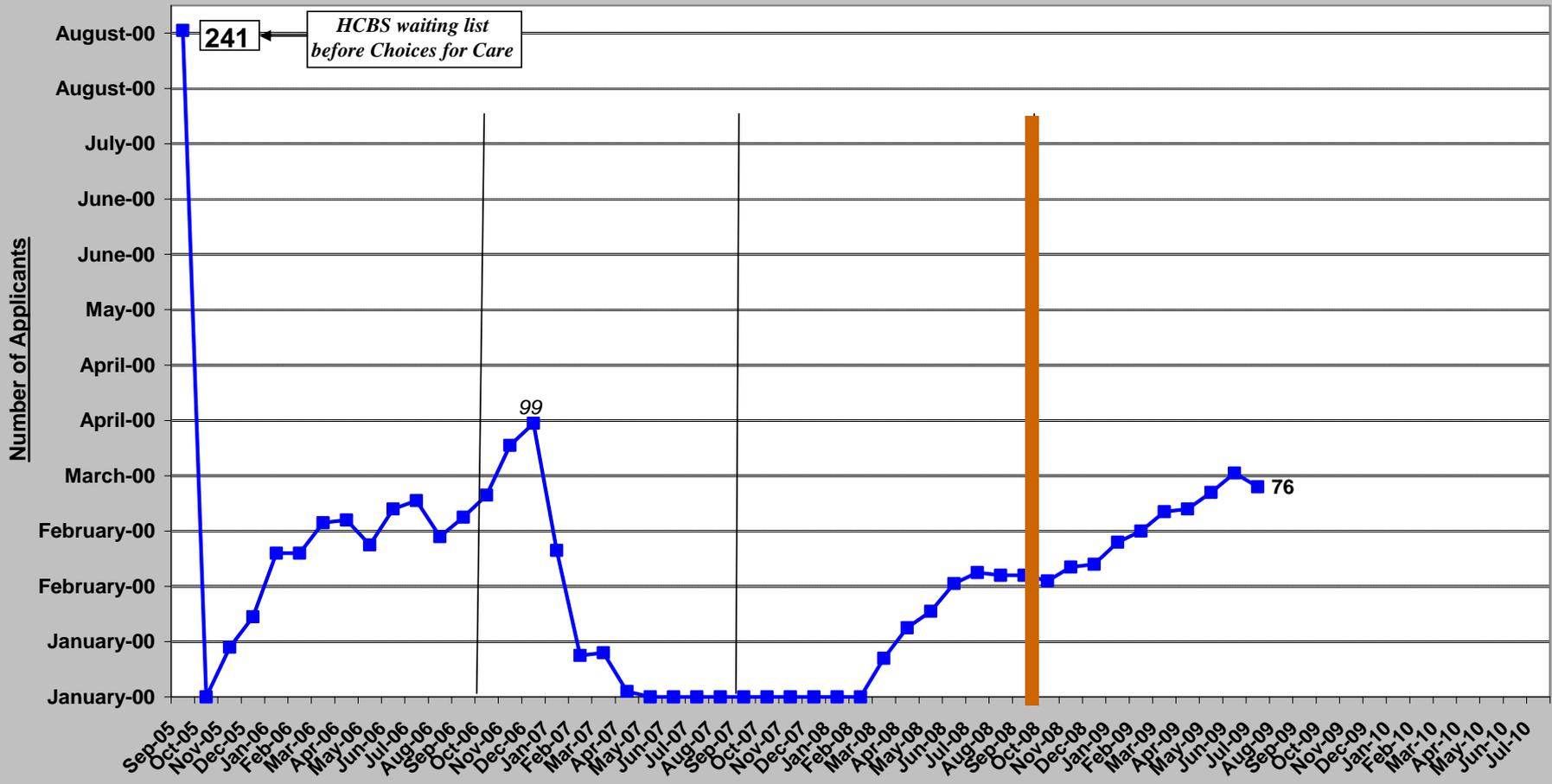
Encourage case management agencies to connect CFC participants to quality of life-related supports

6. High Needs Applicant List

- Applicants List was designed to give service priority to individuals with highest need at time of CFC budget constraints.
- The Applicants List was active for 24 months out of 36 months.

6. High Needs Applicant List (cont.)

Choices for Care High Needs Applicant List, by Month
September 2005 - July 2009



2008: Enrollment/Applicants List

- Special circumstances enrollment data in 2005-2008 shows no pattern favoring nursing facility admissions over HCBS or ERC enrollment.
- Between October 2005 and 2008, number of CFC enrollees exceeded number on high needs applicants list in any given month.
- Per UMMS recommendation in Applicants List policy review, DAIL began to formally document individuals on applicants list and any changes in their clinical status.

6. High Needs Applicant List (cont.)

Indicators (all from SAMS)	Years 1-3		
1. Number of high needs applicants <i>admitted to HCBS under special circumstances</i>	50 (40% of 123 total)		
2. Number of high needs applicants <i>admitted to ERCs under special circumstances</i>	15 (12% of total)		
3. Number of high needs applicants <i>admitted to nursing facilities under special circumstances</i>	58 (47% of total)		
Indicators (all from SAMS)	Year 1	Year 2	Year 3
4. Average monthly number of individuals on the high need applicant list.	50^a	50	35

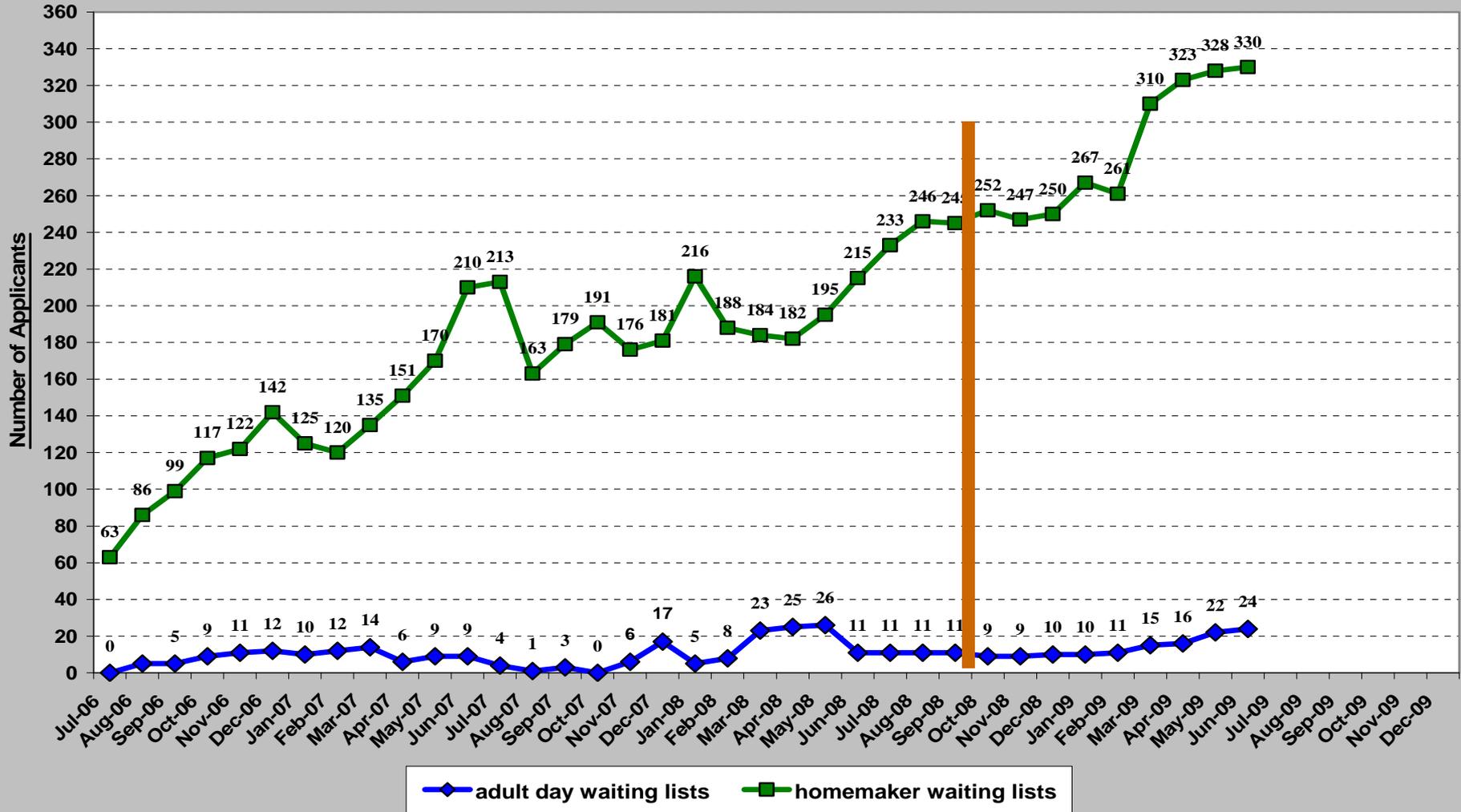
Note: Calculated using the number of months in the year where the applicant list was greater than 0.

6. Applicants List: Recommendations

- Continue to document individuals on applicants list and any changes in their eligibility
- Monitor the length of time individuals are on the applicants list, their self-reports of falls and hospitalizations, and service utilization

6. Moderate Needs Waiting Lists

Choices for Care: Moderate Needs Group Waiting Lists by Type of Service
SFY2006 - SFY 2010



6. Moderate Needs Waiting List

- Homemaker waiting list far surpassed adult day waiting list.

Recommendation:

- Explore self-direction as a way to alleviate waiting list

7. Budget Neutrality

- CFC has remained budget neutral thus far.
- Spending was within 1% of appropriations in each year
- Annual appropriations as a percentage of CMS annual projections increased steadily across the three years--64%, 71%, and 84%.

	FFY06	FFY07	FFY08
CMS Projections	\$205,361,772	\$204,107,689	\$224,585,803
	SFY06	SFY07	SFY08
Appropriations	\$141,783,616	\$147,512,534	\$ 189,793,638
Actual Spending	\$140,087,565	\$147,869,913	\$ 190,510,654

8. Public Awareness of LTC setting

- Legislature is starting to explore long-term care partnership to encourage purchasing of private long-term care insurance
- No data exists of general Vermont population's self-assessed awareness of long-term care options
- CFC participants at hospital discharge reported receiving information on long-term care options (79% in year 2, 83% in year 3); almost all respondents reported being involved in decision-making at time of discharge (which may have been before or after enrollment into CFC)

8. Public Awareness: Recommendation

Develop public awareness campaign, and collect data related to impacts on the public awareness

9. Health Outcomes

- In year 3, when asked compared to others their age, good to excellent “general health” was reported by:
 - 65% of oldest (85+)CFC community-dwelling consumers
 - 51% of older “ “
 - 39% of younger “ “
 - Reports of good to excellent “general health” was up in year 3 (51%), from 41% in year 2.

Concluding Remarks

- CFC has created new HCBS options and increased substantially the total number of HCBS and ERC participants since October 2005.
- Survey data showed high satisfaction with CFC services for each of the three years, with some observed improvements from year 1 to year 3.
- Some client subgroups exhibited higher ratings than others in year 3.

Concluding Remarks (cont.)

- CFC should ensure that HCBS/ERC participants (particularly those at immediate risk of nursing home residency) receive assistance to take advantage of all available supports (whether funded by CFC or other resources) for community living.
- To further reduce NF census, extra efforts in diversion (LTCCC options education to NF admissions and discharge planners) and transition (funding to pay for transition costs, such as rental deposits) should be considered.

Questions or Comments

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