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Vermont Choices for Care: Evaluation of Years 1-9

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Executive Summary: CFC Evaluation Years 1-9

In October 2005, Vermont implemented Choices for Care (CFC), an 1115 research and demonstration waiver that allowed the state to rebalance its system of long-term services and supports by “serving a lower percentage of people in nursing homes and a higher percentage in alternative settings” (Vermont Department of Disabilities, Aging and Independent Living, 2014). The purpose of CFC is to ensure that eligible older adults and people with disabilities have access to long-term services and supports in a setting of their choice. To achieve this goal, CFC encompasses a continuum of long-term services and supports including home and community-based services (HCBS), nursing facilities, and Enhanced Residential Care (ERC) settings.

In 2012, the Evaluation Team at the University of Massachusetts Medical School, in collaboration with Vermont, revised the CFC evaluation plan to focus on specific outcomes for which data are available and that are actionable, have policy relevance, and encompass the continuum of settings (including nursing facilities and ERCs).

The dashboard tables throughout the report present the findings of the evaluation, highlighting progress since 2006 and since 2013. In some instances, as noted within the report, data was first available in 2010. The dashboard style is a convenient format for identifying trends at a glance. Throughout the report, symbols are used to represent trends in comparison to 2013 and 2006: the plus sign (+) indicates a positive trend, the minus sign (-) indicates a negative trend and the equal sign (=) indicates that things have remained the same. In some instances, this requires “reverse coding”, as when an increase in the number of cases awaiting eligibility determination or an increase in number of complaints is depicted with a minus sign, showing a negative or undesirable trend. The methodology for indicating a trend is used in the dashboard tables and the text. Meaning that a change in ratings from 0% - 3% is indicated by an equal sign (=) and usually described as consistent, maintenance or comparable; a change greater than 3% is indicated by a plus sign (+) or minus sign (-) and described as either an increase or decrease.

Choices for Care enrollment grew over the years of the demonstration and this growth continued in year nine. Overall data indicate that CFC improved or maintained positive gains in many domains and decreases in others. In this report, we document the progress of the CFC program in achieving its goals and make recommendations to further strengthen its capacity to serve elderly persons and persons with disabilities.

Selected key findings include:

Strengths of the Program

- CFC maintained a high level of quality and satisfaction.
- CFC increased its ability to serve participants in the community. More participants are being served in HCBS settings than in nursing facilities statewide and in ten out of fourteen Vermont counties. The vast majority of CFC participants agree that their current residence is the setting in which they choose to receive services.
- A substantial majority of CFC participants reported that their needs and preferences (HCBS) or choices and preferences (NF and ERC) were met.
- CFC remained budget neutral.
- Self-rated health among HCBS participants remained steady.
- There was no waiting list for individuals in the High Needs group for the fourth consecutive year.
- CFC developed new service options and funding to reduce the Moderate Needs Group waiting lists

Areas for Improvement

- Person-centered planning represents an area for possible improvement, which may be facilitated by changes to the independent living assessment, care planning and case management processes, incorporating the use of interdisciplinary care management teams.
- Although CFC participant's ratings on a number of quality of life indicators remained high, HCBS participants' ratings of satisfaction with social life and how they spend their free time were low.
- Family and friends were an important source of information about HCBS for CFC participants followed closely by Area Agencies on Aging (AAA). More could be done to ensure that doctors, hospitals and nurses are sources of information about HCBS options for CFC participants.
- The number of applicants waiting for financial eligibility determinations increased.
- CFC participants' ratings of the adequacy of staffing in nursing facilities remain below the national average, but ratings of the competency of staff in both nursing facilities and ERCs remain high.
- Rates of problems experienced by some HCBS participants fell, but participants reported high rates of problems that remain unresolved.
- The HCBS program continued to experience problems with staff training and professionalism. \
- Additional strategies could be implemented to further reduce the Moderate Needs Group waiting list.
- The consistency of the evaluation framework and questions utilized across settings could be improved.
- Non-medical providers could be added to the program to enhance choice and amount of services available.

1. Information Dissemination

1. Information Dissemination: CFC participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with participant's expressed preferences and needs.			
Question 1.1: To what extent do participants receive information to make choices and express preferences regarding services and setting?	2014	Comparison to 2013	Comparison to 2006
1a. Percentage of HCBS participants rating "good" or above to "how would you rate how well people listen to your needs and preferences?"	89%	=	=
1b. Percentage of NF participants rating setting "good" or above to "meeting the resident's choices and preferences" (Note: Measure 1b. data was reported by facility-based setting for 2013)	87%	=	New
1b. Percentage of ERC participants rating setting "good" or above to "meeting the resident's choices and preferences" (Note: Measure 1b. data was reported by facility-based setting for 2013)	94%	=	New
2a. Percentage of HCBS participants responding to different answers to "how did you first learn about the long-term care services you receive?"*	Friend/Family/Word of Mouth/Other Children		23%
	Area Agency on Aging (AAA)		22%
	Doctor, Nurse, health care provider		18%
	Home Health Agency		17%
	Hospital		11%
2b. Percentage of NF participants responding to different answers to "what is the most important reason you (or your family) chose this facility?"	Good Reputation		31%
	Hospital, Doctor recommendation		16%

1. Information Dissemination: CFC participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with participant's expressed preferences and needs.			
Question 1.1: To what extent do participants receive information to make choices and express preferences regarding services and setting?	2014	Comparison to 2013	Comparison to 2006
	Relative, friend recommendation		7%
3. Percentage of HCBS participants rating "good" or above to "how would you rate the amount of choice and control you had when you planned the services or care you would receive?"	81%	=	=
4. Percentage of HCBS participants who "agree" or above to "My current residence is the setting in which I choose to receive services"	95%	=	New

= 2014 results not different (0-3% difference)

+

2014 results better (trend in a positive direction)

- 2014 results worse (trend in a negative direction)

New Measure is new; no comparison available

* Qualitative, no comparisons are made

CFC maintained high ratings related to how well people listened to HCBS participants' needs and preferences. Nursing facility and ERC participants also reported high ratings on a comparable measure. These measures were consistently high across settings (89% - 94%) indicating that CFC participants received the support necessary to choose the long-term care setting consistent with their expressed preferences and needs. A high percentage of CFC participants in all settings agreed that the setting in which they resided was the one where they choose to receive care.

HCBS participants first learned about their services from a variety of agencies and sources, with family and friends emerging as the most common source for 23% of participants and AAAs being the next most common source at 22%. Doctors, nurses and hospitals were a less frequent source of information about HCBS. Nursing facility and ERC participants chose facilities for various reasons, the most common of which were good reputation (31%) and hospital or doctor recommendation (16%).

The percentage of HCBS participants who highly rated their amount of choice and control (84%) remained the same compared to 2013 and 2006, indicating a possible area for improvement that may merit further exploration.

2. Access

2. Access: CFC participants have timely access to long-term care supports in the setting of their choice.			
Question 2.1: Are people able to receive CFC services in a timely manner?	2014	Comparison to 2013	Comparison to 2006
5a. Percentage of HCBS participants rating "good" or above to "how would you rate the timeliness of your services?"	84%	=	+
5b. Percentage of NF participants rating setting "good" or above to "providing an adequate number of (nursing) staff to meet care needs"	68%	=	New
7a. Number of applicants "pending financial eligibility"	478	-	New
7b. Number of applicants awaiting DAIL clinical eligibility**	90	+	New

2. Access: CFC participants have timely access to long-term care supports in the setting of their choice.			
Question 2.2: To what extent are CFC participants receiving the types and amount of supports consistent with their needs and preferences?	2014	Comparison to 2013	Comparison to 2006
8. Number and percentage of Long-term Care Ombudsman complaints from CFC HCBS participants regarding CFC service scope or amount**	80	-	N/A
9a. Percentage of HCBS CFC participants rating "good" or above to "how would you rate the degree to which the services meet your daily needs?"	89%	=	=
9b. Percentage of NF participants rating setting "good" or above to "meeting your need for grooming"	79%	=	New
9c. Percentage of NF participants rating setting "good" or above to "the competency of staff"	89%	=	New
9c. Percentage of ERC participants rating setting "good" or above to "the competency of staff"	94%	=	New

= 2014 results not different (0-3% difference)

+

2014 results better (trend in a positive direction)

- 2014 results worse (trend in a negative direction)

New Measure is new; no comparison available

** Reverse coded = a lower number is a better result, while a higher number is a worse result

CFC has not made substantial gains over time, but maintained similar percentages of HCBS participants rating timeliness of services as good or above. Nursing facilities and ERCs continue to rate less highly in the timeliness measure which examines adequacy of nursing staff to meet care needs. HCBS participants in various programs gave high ratings to when they received services or care. In comparison to 2014, more applicants were waiting for financial and eligibility determination.

Adequacy of nursing facility staffing continued to receive low ratings, while ratings of staff competency remained high.

Ombudsman complaints related to CFC HCBS participants numbered 80, representing a substantial decrease in complaints from last year. The most common complaints were regarding Home Health Agency (HHA) staff (insufficient staff, not being notified of schedule changes and not getting the quantity of hours authorized.) Other more common complaints regarding a variety of providers and agencies included inadequate staff training and issues with quality of service. Improvements in meeting the daily needs of HCBS participants were realized this year. Nursing facility and ERC participants highly rated the competency of staff to provide the services they need, but did not rate grooming assistance as strongly.

Overall, participants continue to express satisfaction regarding access to the types and amount of supports they need and want. However, timeliness of services is an area that could be further examined for improvements across settings.

3. Effectiveness

3. Effectiveness: Participants receive effective HCBS to enable participants to live longer in the community.			
Question 3.1: Is CFC increasing in its ability to serve participants in all CFC levels of need in the community?	2014	Comparison to 2013	Comparison to 2006
10. Number of individuals on waiting list for High Needs**	0	=	+
11. Percentage of CFC participants residing in nursing facilities out of total CFC participants in the highest and high levels of need	48%	=	+
12. Number of licensed nursing home beds**	3,115	+	+

3. Effectiveness: Participants receive effective HCBS to enable participants to live longer in the community.				
Question 3.1: Is CFC increasing in its ability to serve participants in all CFC levels of need in the community?		2014	Comparison to 2013	Comparison to 2006
13. For CFC participants in the highest, high, and moderate levels living in the community, percentage of participants rating "good" or above to "how would you rate the degree to which the services meet your daily needs?" (NOTE: Data were only available for 2010-2014.)	Personal Care	92%	=	=
	Flexible Choices	86%	+	=
	Homemaker Services	83%	=	=
	Adult Day Center	90%	=	+
	Adult Family Care	100%	New	New
Question 3.2: To what extent are participants' long-term care supports coordinated with all services?		2014	Comparison to 2013	Comparison to 2006
14. Percentage of HCBS participants reporting "almost always" or above to "I feel I have a part in planning my care with my case manager or support coordinator"		86%	=	New
15. Percentage of HCBS participants reporting "almost always" or above report to "my case manager or support coordinator coordinates services to meet my needs"		85%	=	New
Question 3.3: To what extent does Medicaid nursing facility residents' acuity change over time?		2014	Comparison to 2013	Comparison to 2006
16. Case Mix Acuity		1.098	=	=

= 2014 results not different (0-3% difference)

+

2014 results better (trend in a positive direction)

- 2014 results worse (trend in a negative direction)

New Measure was new for 2013; no comparison available

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CFC continued to serve participants in all CFC levels of need in the community as demonstrated by the nonexistence of a High Needs Group waiting (applicant) list. The percentage of CFC participants residing in nursing facilities has fallen below 50% and the number of licensed nursing facility beds decreased while capacity to serve individuals choosing this setting was maintained.

Problems reported by participants receiving personal care and adult day center services fell substantially, but the rate of problems that remained unresolved in all programs was high.

CFC's overall service coordination and planning of services remained consistent with last year. However, these areas continue to highlight opportunities for improved care coordination and person-centered planning.

4. Experience with Care

4. Experience with Care: Participants have positive experiences with the types, scope, and amount of CFC services.				
Question 4.1: To what extent do CFC participants report positive experiences with types, amount and scope of CFC services?		2014	Comparison to 2013	Comparison to 2006
17a. Percentage of HCBS participants rating "good" or above to "how would you rate the overall quality of the help you receive?"		89%	=	=
17b. Percentage of NF participants rating setting "good" or above on "the quality of care provided by the nurses"		90%	=	New
17c. Percentage of NF participants rating setting "good" or above on "the quality of care provided by the nursing assistants"		88%	=	New
17c. Percentage of ERC participants rating setting "good" or above on "sufficiency of healthcare needs"		95%	=	New
17c. Percentage of ERC participants rating setting "good" or above on "sufficiency of personal assistance"		97%	=	New
18a. Percentage of HCBS participants rating "good" or above on "How would you rate the courtesy of those who help you?"		96%	=	=
18b. Percentage of NF participants rating setting "good" or above on "the staff's care and concern for you"		88%	=	New
18b. Percentage of ERC participants rating setting "good" or above on "the staff's care and concern for you"		97%	=	New
20a. Percentage of HCBS participants who reported experiencing "any problems with services during the past 12 months"*** (NOTE: Data were only available for 2010-2014.)	Personal Care	16%	=	=
	Flexible Choices	6%	-	=
	Homemaker services	23%	=	+
	Adult Day Center	5%	-	=
	Adult Family Care	0%	New	New
20b. Percentage of HCBS participants who reported experiencing "any problems with services during the past 12 months" who reported that staff worked "to resolve any problems" (NOTE: Data were only available for 2010-2014.)	Personal Care	59%	=	+
	Flexible Choices	24%	-	+
	Homemaker services	62%	-	-
	Adult Day Center	49%	-	+
	Adult Family Care	0%	New	New
20c. Percentage of NF participants rating setting "good" or above on "management's responsiveness to your suggestions and concerns"		81%	=	New
20c. Percentage of ERC participants rating setting "good" or above on "management's responsiveness to your suggestions and concerns"		94%	+	New
21a. Percentage of HCBS participants reporting "somewhat satisfied" or above to	Personal Care	95%	=	=

4. Experience with Care: Participants have positive experiences with the types, scope, and amount of CFC services.				
Question 4.1: To what extent do CFC participants report positive experiences with types, amount and scope of CFC services?		2014	Comparison to 2013	Comparison to 2006
"how satisfied are you with the services you receive?" (NOTE: Data were only available for 2010-2014.)	Flexible Choices	92%	=	=
	Homemaker services	93%	=	—
	Adult Day Center	94%	=	=
	Adult Family Care	100%	New	New
21b. Percentage of NF participants rating setting "good" or above on "how would you rate your overall satisfaction?"		87%	=	New
21b. Percentage of ERC participants rating setting "good" or above on "how would you rate your overall satisfaction?"		93%	=	New

= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)
 - 2014 results worse (trend in a negative direction) New Measure is new; no comparison available
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CFC maintained a high level of quality and satisfaction across HCBS settings. Nursing facility participants rated nursing care highly. ERC participants gave very high ratings for the sufficiency of health care needs and personal assistance. HCBS participants continued to report high levels of staff courtesy, while nursing facility and ERC participants reported similarly high levels of satisfaction with staff care and concern.

Some HCBS participants continue to experience difficulties with problems that remain unresolved. Although Adult Day Centers were rated less highly this year, the program has a lower percentage of problems overall and greater percentage of resolutions compared to other HCBS programs. Alternatively, Flexible Choices had the lowest percentage of resolutions and experienced a substantial decrease in participants reporting that staff worked to resolve problems from 67% in 2012 to 49% in 2013. Other HCBS programs could benefit from lessons learned from the Adult Day Centers.

5. Quality of Life

5. Quality of Life: Participants' reported that their quality of life improves.				
Question 5.1: To what extent does CFC participants' reported quality of life improve?		2014	Comparison to 2013	Comparison to 2010***
22. Percentage of HCBS CFC participants reporting "somewhat better" or above to "Has the help you receive made your life...?"	Personal Care	91%	=	=
	Flexible Choices	94%	-	+
	Homemaker services	86%	=	=
	Adult Day Center	85%	=	=
	Adult Family Care	83%	New	New
23a. Percentage of HCBS participants reporting "somewhat" or above to "I am satisfied with how I spend my free time"		72%	+	=
23b. Percentage of NF participants rating setting "good" or above on "offering you meaningful activities"		83%	-	New

5. Quality of Life: Participants' reported that their quality of life improves.			
Question 5.1: To what extent does CFC participants' reported quality of life improve?	2014	Comparison to 2013	Comparison to 2010***
23b. Percentage of ERC participants rating setting "good" or above on "offering you meaningful activities"	89%	=	New
23c. Percentage of HCBS participants reporting "somewhat" or above to "I have someone I can count on to listen to me when I need to talk"	83%	=	=
23d. Percentage of NF participants rating setting "good" or above on "meeting your religious and spiritual needs"	88%	=	New
23e. Percentage of ERC participants rating setting "good" or above on "meeting your religious and spiritual needs"	85%	=	New
23f. Percentage of HCBS participants reporting "somewhat" or above to "I feel satisfied with my social life"	60%	+	=
23g. Percentage of NF participants rating setting "good" or above on "offering you opportunities for friendships with other residents"	88%	-	New
23h. Percentage of ERC participants rating setting "good" or above on "offering you opportunities for friendships with other residents"	97%	-	New
23i. Percentage of HCBS participants reporting "somewhat" or above to "I have someone I can count on in an emergency"	89%	=	=
23i. Percentage of HCBS participants reporting "somewhat" or above to "I feel prepared for an emergency"	70%	New	New
23j. Percentage of NF participants rating setting "good" or above on "offering you opportunities for friendships with staff"	90%	=	New
23k. Percentage of ERC participants rating setting "good" or above on "offering you opportunities for friendships with staff"	89%	=	
23l. Percentage of HCBS participants reporting "somewhat" or above to "I feel safe in the home where I live"	90%	-	=
23m. Percentage of NF participants rating setting "good" or above on "how safe it is for you"	93%	=	New
23n. Percentage of ERC participants rating setting "good" or above on "how safe it is for you"	96%	=	New
24. Percentage of HCBS participants who "agree" or above to "My services help me to achieve my personal goals"	90%	-	New

== 2014 results not different (0-3% difference)

+

2014 results better (trend in a positive direction)

- 2014 results worse (trend in a negative direction)

New Measure is new; no comparison available

*** Methodology changed and earlier results not comparable

Overall, results were maintained or improved for most quality of life measures in this ninth year, with the notable exception of ratings on satisfaction with social life and how one spends one's free time. CFC continued to have high ratings across programs for making participants lives better. Nursing facility and ERC participants had positive reports about the availability of meaningful activities and opportunities for friendships with other residents and staff. .

6. Waiting List

6. Waiting List: CFC applicants who meet the High Needs criteria will have equal access to services regardless of the setting of their choice (e.g. nursing facility, enhanced residential care, and home care).			
Question 6.1: In the presence of an active waiting list, to what extent does the implementation of a waiting list for the High Needs group in Choices for Care have different impact on applicants waiting to access home and community-based services versus nursing facility services?	2014	Comparison to 2013	Comparison to 2006

6. Waiting List: CFC applicants who meet the High Needs criteria will have equal access to services regardless of the setting of their choice (e.g. nursing facility, enhanced residential care, and home care).

25. Percentage of CFC applicants on the High Needs waiting list who are waiting for HCBS, compared with applicants waiting for ERCs, and nursing facilities**	No waiting list	=	+
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= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)

The High Needs Group waiting (applicant) list ended in February 2011. This represents a positive outcome since 2006 when the HCBS waiting (applicant) list consisted of 241 individuals. While not an official measure on the evaluation plan, 449 individuals remained on the Moderate Needs Group waiting (applicant) lists as of January, 2015 even though there were unspent funds which the state had allocated to the Home Health Agencies and to the Adult Day Centers to serve individuals in the Moderate Needs Group. This represents a potential area for improvement

7. Budget Neutrality

7. Budget Neutrality: Medicaid cost of serving CFC participants is equal to or less than the cost to provide Medicaid services without the Demonstration.

Question 7.1: Are the total costs of serving CFC participants less than or equal to the projected maximum costs for serving this population in the absence of the waiver?			2014	Comparison to 2013	Comparison to 2006
26. Total annual CFC expenditures by setting	HCBS (including ERC)	\$59,370,598	28.9%	=	New
	Nursing facility	\$118,298,502	57.7%	=	New
	Acute	\$27,491,139	13.4%	=	New
27. Percentage of Medicaid expenditures for nursing facilities for Highest and High Needs participants in comparison with Medicaid community services for all participants			66.6%	=	New
28. Total appropriations versus actual expenditures			The Long Term Care portion of the Choices for Care budget was under budget by \$5,593,331 thru the end of SFY14.		
29. How surplus was reinvested*			SY2014 unobligated funds (\$3,078,908) are proposed to be reinvested in the following main categories: <ul style="list-style-type: none"> • Providing funds for Support and Services at Home (SASH) • Providing funds for home modifications • Address Moderate Needs group waitlist 		

New Measure is new for 2012; no comparison available * Qualitative, no comparisons are made

DAIL effectively used its state appropriation to provide services across the long-term services and supports continuum and to maintain CFC budget neutrality. Expenditures remained somewhat below appropriations. CFC used its unobligated funds to reinvest in SASH and home modification services and to address the Moderate Needs Group waiting (applicant) list.

8. Health Outcomes

8. Health Outcomes: CFC participants' medical needs are addressed to improve self-reported health.			
Question 8.1: To what extent are CFC participants' medical needs addressed to improve self-reported health?	2014	Comparison to 2013	Comparison to 2006
30. Percentage of HCBS participants whose rating of their general health is "good" or better (NOTE: Data were only available for 2010-2014.)	48%	=	=
31. Percentage of HCBS participants who "agree" or above to "My services help me to maintain or improve my health"	93%	+	New
32. Percentage of HCBS participants reporting "almost always" or above to "My case manager or support coordinator understands which services I need to stay in my current living situation"	87%	=	New

= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)
 - 2014 results worse (trend in a negative direction) New Measure is new; no comparison available

Although participants do not rate their health highly in comparison to other Vermonters, an increased number of CFC participants reported that their services help to maintain or improve their health. The ratings indicate that case management and support coordination were helpful to maintain individuals in the community.

9. Service Array and Amounts

9. Service Array and Amounts: Array and amounts of services available in the community to people who are eligible for CFC increase.				
9.1 Does CFC further growth and development of home and community based services and resources throughout the state?	2014	Comparison to 2013	Comparison to 2006	
33. Number of CFC participants by Nursing facilities, ERCs, PCA, Flexible Choices, Homemaker, Adult Day Center, 24 hour care, paid spouses	Nursing facilities**	1,847	+	+
	ERCs	444	+	+
	PCA	1,346	+	+
	Flexible Choices	266	+	+
	24 hour care	33	+	+
	Paid Spouses	37	+	+
	Adult Day Center (Highest and High Needs)	189	+	+
	Adult Day Center (Moderate Needs Group)	121	-	+
	Homemaker (Moderate Needs Group)	1,074	+	+

Conclusions and Recommendations

As Choices for Care is folded into the Global Commitment, DAIL has an opportunity to more closely align its performance improvement efforts with the “Triple Aim” by improving the experience of care, improving the health of populations, and reducing costs (Berwick, Nolan and Whittington, 2008).

Information Dissemination

The Evaluators recommend that DAIL continue its support of the work of the Aging and Disability Resource Connection (ADRCs) to increase awareness of the long-term support services program while ensuring that awareness of HCBS residential settings is also included. In particular, the evidence suggests that doctors, nurses and hospitals are not aware of all of the HCBS residential settings. From the most recent policy brief on factors which can influence the return of transitioned CFC participants to a nursing facility, it was suggested that this lack of awareness of community alternatives among health care providers was a potential factor facilitating readmission to a nursing facility. Vermont has made strides in addressing this issue with initiatives such as the implementation of the Universal Transfer Protocol as a pilot project, but there may be other steps that it could take as well. In addition to doctors, nurses and hospitals, caregivers were also often not always aware of the full spectrum of residential settings available (Long-Bellil, Henry, and Cumings, 2015). Working with the ADRC and case managers to improve marketing and outreach may help to address this issue.

An essential group to include in outreach efforts is hospital discharge planners. Vermont’s ADRC can build on the relationships that exist in those hospitals where representatives from the AAA and the HHA already participate in the daily discharge team meetings to pilot a training and peer-to-peer support program. DAIL should work with the ADRC to reach out to discharge planners to determine their knowledge and awareness of long-term support services in the community for elders and people with disabilities; use this information to develop an in-person training; and explore the opportunities for establishing a peer-to-peer support system wherein discharge planners can reach out to a designated ADRC partner when questions arise.

Access

Data shows that since 2011, the number of individuals waiting more than 60 days for financial eligibility determination for CFC has increased. This time frame meets federal standards, which have been relaxed over the last few years, but is not consistent with DAIL’s goals for the program. Given the barriers that exist to gathering this documentation at a time when applicants may be least able to assist in that process, shortening these time frames is a daunting task, but one which may be worth taking on because of the potentially positive impact that reduced time frames might have on applicants. Working with the Department of Children and Families (DCF), DAIL may want to consider implementing a performance improvement initiative to identify and to track the reasons for the delay in completing financial eligibility determinations. The information gained from this process could provide DAIL and DCF with actionable data which can be used to identify next steps. Although case managers should continue to play an important role, DAIL may find it useful to work with the ADRC to explore public and private grant funding options which can support a pilot to include additional staff, such as the Health Navigators or similar personnel, in the process of assisting applicants in collecting and submitting their financial paperwork.

The identification of services that participants state they want, but cannot get, raises the question of whether their needs could be better assessed and met with a revised assessment process that incorporates input from an interdisciplinary care team. As noted in the most recent policy brief, a more in-depth evaluation with input from practitioners representing various disciplines, accompanied by a more comprehensive care plan, has the potential to create a better fit between the individual’s needs and the care they receive. Organizations such as the Commonwealth Care Alliance in Massachusetts and similar programs across the country can serve as models for such a revised approach.

Experience with care

According to this year’s Consumer survey, the percentage of individuals identifying problems within specific CFC programs decreased. However, the percentage of those problems that were successfully resolved also decreased. DAIL may find it useful to address this issue by requiring providers to document complaints and their resolution. This

information could then be reported to DAIL at regular intervals, such as during DAIL quality reviews or be made available to DAIL upon request. Another alternative could be to require that they be reported to the Ombudsman.

Although all CFC participants receive materials about the Ombudsman's office at the time of enrollment, additional outreach may be necessary to increase their awareness of the Ombudsman's office as a resource. DAIL can work with the Ombudsman's office, and perhaps with the ADRC, to ensure that all CFC participants are informed about the role of the Ombudsman's office such as disseminating outreach materials to health care providers and organizations frequented by elders such as senior centers and adult day programs or conducting targeted outreach via mail or telephone. This outreach effort would be particularly important for individuals who direct their own care and therefore do not have an agency to turn to when problems arise.

Despite the best efforts of all involved, there continued to be problems with staff training and professionalism. Participants identified issues of staff dependability, staff misrepresentation of their qualifications, staff rudeness and staff quality overall, as factors which impact the services they use. The Evaluation Team encourages DAIL to work with agency and independent providers to implement solutions to staffing problems, including the adequacy, management and training of staff. Online training for agency and independent workers may be one approach to addressing this issue. DAIL may find it useful to build upon current training efforts conducted by the home health agencies. Additionally, DAIL may find it useful to work with an outside contractor who could engage CFC participants, family members, providers and the union to devise additional training. DAIL could also explore training efforts underway in other states. For example, Massachusetts has developed an online competency training strategy with input from stakeholders by which may serve as a model as could the training program developed by the state of Maine. The local Area Health Education Centers (AHECs) and community colleges may serve as helpful resources in developing and disseminating training as well. Such training can be one concrete step that DAIL could take to address the need for a more skilled direct care workforce

Lastly, although Flexible Choices participants rated certain aspects of the program highly, their rating of the amount of choice and control (82%) and the extent to which services meet their daily needs (86%) were lower than one might expect from a self-directed program. In the 2010 Self-Determination policy brief, DAIL gained information on the functioning of the different aspects of the Flexible Choices program; moving forward, DAIL may find it worthwhile to conduct a more in-depth assessment of the Flexible Choices program participants' experiences in a future policy brief.

Effectiveness

The principles and practice of person-centered planning have long been part of the Choices for Care program. As DAIL embarks on the process of revising the standards for case managers, this may be an advantageous time for DAIL to use an outside contractor to engage case managers in an open discussion of their perceptions of the intersection and impact of person-centered principles and theories and every day practice (Clemens, Wetle, Feltes, Crabtree and Dubitzky, 1994). DAIL may also find it useful to explore the experiences of consumers and caregivers with respect to person-centered planning. The outcome of these conversations could then be incorporated into an interdisciplinary team approach.

The suggestion made above and in the most recent policy brief about revising the independent living assessment and care planning processes are also important steps toward creating a more person-centered system. Therefore, DAIL should contract with an outside entity to lead the effort to revise the ILA tool and the care planning tool.

As part of this effort to further realize its person-centered system, DAIL should involve CFC participants and their caregivers either through the Advisory Board or other standing committees or through more individual outreach. DAIL needs to ensure that in addition to case managers there are other sources which can inform participants and their caregivers of their role in the person-centered process. DAIL can also involve participants and caregivers in articulating their role in the person-centered planning process and to identify avenues for communicating that information with subsequent CFC participants, caregivers and professionals.

Quality of Life

As the use of CFC services ultimately impacts the quality of life of participants, it is important that DAIL establish a work group to explore specific factors. One area to begin may be the issue of participants indicating that they are not “prepared in case of an emergency”. DAIL may find it useful to ensure that case managers are aware that they should address this issue by emphasizing its importance as part of the process of care planning or through some other mechanism. Working with the partners of the ADRC, DAIL can also ensure that CFC participants are aware of the steps they can take to prepare for an emergency.

Additionally, DAIL may want to consider collaborating with other entities to explore opportunities for improving CFC participants’ satisfaction with their social lives and with the way they spend their time. Innovative approaches to transportation utilizing ridesharing and volunteers such as ITNGreaterBoston, opportunities for interventions using a group format and technological solutions such as a “Virtual Senior Center” should all be considered. A revised assessment and care planning process should include a greater emphasis on social life and activities and the transportation services necessary to enhance access to these important aspects of life in the community.

Waiting Lists

As noted previously, the waiting list for the High Needs program ended in 2011. However, there continues to be a substantial waiting list for the Moderate Needs Group (MNG) program. The state allots MNG funds to the agencies, which are then responsible for providing services to eligible individuals. Each agency is responsible for managing its own waiting list. The number of people on those waiting lists varies substantially between agencies. Historically, some agencies have not been able to use all of their allotted funding, despite having a waiting list of eligible individuals. Although the number of individuals potentially eligible for MNG services makes the elimination of a waiting list unlikely, DAIL may find it useful to form a workgroup to examine how waiting lists are managed and formulate mechanisms for reducing them to the extent possible. Such mechanisms could include the use of pay for performance incentives.

Service Array and Amounts

In the 2012 policy brief, we recommended that Vermont adopt a two-year pilot to permit non-medical providers to offer services to CFC participants. Full adoption of this approach has the potential to expand CFC participants’ choice of provider and could be an important step forward in promoting choice and ensuring that their needs are met.

Evaluation

In 2012, the evaluation plan was revised to encompass an assessment of services across the continuum of care. It was recognized that in order to do an accurate assessment of participant experiences across the continuum of care, the same question should be asked across all settings. Currently the survey instruments used by the contracted organizations conducting nursing facility, Enhanced Residential Care/Assisted Living and home and community-based services consumer satisfaction assessments have the flexibility to incorporate new questions. DAIL should require the use of the same core framework and questions by all contractors to ensure comparability across the continuum of care.

Conclusion

In its final year as a separate 1115 Research and Demonstration waiver, CFC continues to meet the needs of its participants. This year’s evaluation identified a few new and persistent issues which DAIL should continue to address as the CFC program is incorporated into the Global commitment to Health waiver. With its tradition of innovation, Choices for Care is well positioned to meet the future needs of CFC participants.

Introduction

Vermont's Choices for Care program has achieved many milestones and these continued during its ninth year of operations.

Background:

In October 2005, Vermont's Department of Disabilities, Aging and Independent Living (DAIL) implemented Choices for Care (CFC) an 1115 Research and Demonstration waiver designed to rebalance its system of long-term services and supports by "serving a lower percentage of people in nursing homes and a higher percentage in alternative settings" (Vermont Department of Disabilities, Aging and Independent Living, 2014).

CFC achieves the above, by providing home and community-based services and nursing facility services while giving older adults and individuals with disabilities access to those services in a setting of their choice. In order to implement the provision of CFC services, a three-tiered system was established in which individuals with long-term service and supports needs are identified as: Highest Needs, High Needs or Moderate Needs. Individuals identified as Highest Needs are guaranteed services. Individuals who are identified as High Needs may face a delay in access to services depending on the availability of funding, and may be placed on a waiting (applicant) list. Highest and High Needs individuals meet "Vermont's 'traditional' nursing home clinical and financial eligibility criteria" (see Choices for Care, Data Report, April 2012, p. 6) and can choose the setting in which to receive services (i.e., home, Adult Family Care, ERC, nursing facility). Those individuals who are identified as Moderate Needs are below the level of care that makes one eligible for nursing facility services, may not meet the financial criteria for Medicaid long-term services and supports, and can receive limited Homemaker services, Adult Day Center services and case management services. Similar to the High Needs Group, Moderate Needs Group individuals may also be placed on a waiting (applicant) list.¹ (Trafton and Cumings, 2013) Today, CFC has expanded the service delivery options to include Home and Community-Based Services (HCBS) delivered through consumer-directed care, surrogate-directed care, agency-directed care and two "cash and counseling" options (Flexible Choices and Moderate Needs Flexible Choices); Adult Family Care, Enhanced Residential Care (ERC) settings; and nursing facilities.

During the ninth year of operation, October 2013 – September 2014, CFC furthered the realization of its goals by:

- Ensuring that all stakeholders can fully participate in the meetings of the DAIL Advisory Board and that the internal operating processes of the DAIL Advisory Board are strengthened by writing and publishing on-line its Operations manual;
- Contracting with the UMass Evaluation team for a policy brief examining the personal and system-wide factors which can influence an individual's readmission to a nursing facility after the person is discharged to a community setting;
- Concluding a Collective Bargaining Agreement with the union for independent direct support workers (Vermont Homecare United - AFSCME Local 4802) establishing new minimum wages and wage rates;
- Expanding the service delivery options by implementing the Moderate Needs Group Flexible Funding program; and
- Receiving CMS's agreement to integrate Choices for Care into Vermont's other 1115 Research and Demonstration waiver, the Global Commitment to Health, thereby having one waiver which will incorporate all DLTSS along with all other Medicaid services.

¹ Several waiting (applicant) lists can develop at the Home Health Agencies and the Adult Day Centers that receive funding from the state to serve Moderate Needs Group participants. Each agency creates and maintains its own waiting (applicant) list.

As this is the final year for this evaluation process, it is important to also highlight some system changes which were accomplished by CFC during nine years of operations:

- CFC is making long-term support services equally available in home and community-based settings as in nursing facilities;
- CFC implemented a policy to pay spouses for the provision of personal care services (GC request, 2013);
- CFC expanded the HCBS service delivery options to include Flexible Choices, most recently expanding them to individuals in the Moderate Needs Group, and Adult Family Care;
- CFC, since 2013, has had a greater percentage of participants who received services in the community as in comparison to participants who received services in a nursing facility;
- CFC participants continue to rate their overall satisfaction with the services they receive as Excellent or Good;
- CFC has increased participant choice by having at least two providers of home health services available in each county of the state;

Therefore, as CFC begins its new path as an integrated program of the Global Commitment to Health waiver, CFC brings a legacy of meeting and surpassing goals, responsiveness to its participants and innovation.

Evaluation Framework

DAIL contracted with the University of Massachusetts Medical School (UMMS) in 2007 to serve as an independent evaluator in order to comply with Federal waiver requirements and to gain an objective assessment of the Choices for Care program. To document the evaluation, UMMS produces an annual evaluation report that summarizes CFC activities, participant characteristics and enrollment and findings related to specified outcomes as well as recommendations for potential improvements. Similar to previous annual evaluation reports, this current report builds upon past evaluation data and focuses on the most recent year's (October 2013 through September 2014) evaluation results. With the consolidation of the Choices for Care waiver and the Global Commitment to health waiver, some of this year's recommendations will identify actions which further position CFC for continued success in the future.

The UMMS Evaluation team will use the evaluation plan which emphasizes specific outcomes for which data are available and that are actionable, have policy relevance, and encompass the continuum of settings. In 2012, UMMS revised the evaluation plan adding measures related to individuals in nursing facilities and ERCs, deleted a long-term outcome related to public awareness and added a long-term outcome related to service array and amounts. In adding this section on Service Array and Amounts, DAIL will over time have a concise depiction of participant use of CFC services and the distribution of types of providers.

Short-Term Outcomes:

1. Information Dissemination - Choices for Care participants (and their authorized Representatives) receive necessary information and support to choose the long-term care setting consistent with participant's expressed preferences and needs:
 - 1.1: To what extent do participants receive information to make choices and express preferences regarding services and setting?
2. Access - Choices for Care participants have timely access to long-term care supports in the setting of their choice:
 - 2.1: Are people able to receive CFC services in a timely manner?
 - 2.2: To what extent are CFC participants receiving the types and amount of supports consistent with their needs/choices and preferences?
3. Effectiveness - Participants receive effective home and community-based services to enable participants to live longer in the community:
 - 3.1: Is CFC increasing in its ability to serve participants in all CFC levels of need in the community?

- 3.2: To what extent is participants' long-term care supports coordinated with all services?
- 3.3: To what extent does Medicaid nursing facility residents' acuity change over time?
- 4. Experience with Care - Participants have positive experiences with the types, scope and amount of Choices for Care services:
 - 4.1: To what extent do CFC participants report positive experiences with types, amount and scope of CFC services?
- 5. Quality of Life - Participants' report that their quality of life improves:
 - 5.1: To what extent does CFC participants' reported quality of life improve?
- 6. Impact of Waiting List - Choices for Care applicants who meet the High Needs criteria has equal access to services regardless of the setting of their choice (e.g., nursing home, enhanced residential care, home care):
 - 6.1: In the presence of an active waiting list, to what extent does the implementation of a waiting list for the High Needs Group in Choices for Care have different impact on applicants waiting to access home and community-based services versus nursing facility services?
- 7. Budget Neutrality- Medicaid cost of serving CFC participants is equal to or less than the cost to provide Medicaid services without the Demonstration.
 - 7.1: Are the total costs of serving CFC participants less than or equal to the projected maximum costs for serving this population in the absence of the waiver?

Longer-Term Outcomes:

- 1. Health Outcomes - Choices for Care participants' medical needs are addressed to improve self-reported health:
 - 1.1: To what extent are Choices for Care participants' medical needs addressed to improve self-reported health?
- 2. Service Array and Amounts – Array and amounts of services available in the community to people who are eligible for Choices for Care increase.
 - 2.1: Does Choices for Care further growth and development of home and community-based services and resources throughout the state?

Data Sources and Analyses

To evaluate CFC, information was reviewed from previous policy briefs, minutes of the DAIL Advisory Board, DAIL's annual budget reports, DAIL's testimonies and reports to the Vermont legislature, Vermont Ombudsman Annual Report, Vermont Long-Term Care Consumer Survey, My Innerview Nursing Facility and ERC Resident Satisfaction Survey and bi-monthly meetings with DAIL staff. From these sources, the Evaluation Team obtained information about the functioning of the program and stakeholders' perspectives. To understand on-going CFC operations and provide context for the evaluation, the Evaluation Team analyzed DAIL Advisory Board Meeting Minutes. The Semi-Annual CFC reports to CMS documented the changing environment in which CFC operated during this period. They also documented activities that took place at the state level such as the implementation of the Flexible Choices for Moderate Needs Group participants, the negotiations of the Collective Bargaining Agreement with the union for independent support workers, and the number of complaints made to the Ombudsman's office.

We assessed CFC's progress with respect to outcomes by reviewing the following data sources:

- Vermont Long-Term Care Consumer Survey: UMMS reviewed Thoroughbred Research Group survey data collected in the fall of 2014 through the Vermont Long-Term Care Consumer Survey. Similar to the 2013 survey, the 2014 survey interviewed consumers of the long-term services and supports system and provided data on specific CFC services. This year, Thoroughbred Research Group used a four-point response scale, removing the "neither/nor" response. For the purposes of this report, this change meant that respondents had to select a response option which reflected their experience. With consultation from the Evaluation Team, and DAIL staff Thoroughbred Research Group made the following revisions to the 2014 survey:
- My Innerview Nursing Facility and ERC Resident Satisfaction Survey: This evaluation year, UMMS obtained data from resident satisfaction surveys from the Vermont Health Care Association (VHCA) to include residents in nursing facilities (other than private-pay only) and ERCs to evaluate outcome measures of information dissemination, access, experience with care and quality of life. Survey responses included nursing facilities,

Assisted Living facilities and ERCs; data includes both CFC and non-CFC responses. The distribution of organizational and individual respondents to the My Innerview Survey is presented in the following table.

Organization	Number of Responding Organizations	Number of Respondents
Nursing facility	28	747
Assisted Living including Enhanced Residential Care	20	527

- CFC enrollment and application data: Enrollment data, collected by DAIL as part of the waiver administration, tracked the number of CFC participants, the CFC setting in which they were served, their CFC level of need and waiting (applicant) list information. In addition, DAIL tracked the number of applications to CFC by major CFC settings (nursing facility, ERCs, HCBS, and Moderate Needs Group).
- DAIL calculations of CFC projected 5-year budget, annual appropriations, and actual spending: DAIL reports annual CFC appropriations and actual spending.

The dashboard tables throughout the report present the findings of the evaluation, highlighting progress since 2006 and since 2013. The dashboard style is a convenient format for identifying trends at a glance. Throughout the report, symbols are used to represent trends in comparison to 2013 and 2006: the plus sign (+) indicates a positive trend, the minus sign (-) indicates a negative trend and the equal sign (=) indicates that things have remained the same. In some instances, this requires “reverse coding,” as when an increase in the number of cases awaiting eligibility determination or an increase in number of complaints is depicted with a minus sign, showing a negative or undesirable trend. The methodology for indicating a trend is used in the dashboard tables and the text. Meaning that a change in ratings from 0% - 3% is indicated by an equal sign (=) and usually described as consistent, maintenance or comparable; a change greater than 3% is indicated by a plus sign (+) or minus sign (-) and described as either an increase or decrease.

III. Findings

Profile of CFC Enrollment

Enrollment in CFC grew in year eight, from 5,125 in 2013 to 5300 as of January, 2015 (point in time). During nine years of CFC implementation, total enrollment grew steadily in the first three years before leveling off in 2008 and decreasing slightly in the following years. Enrollment began to rebound in 2012 and since then enrollment has increased at a slow, but steady pace. .

Point-in-Time Enrollment by Level of Need

	Moderate	High	Highest	Total
11/05	2%	7%	91%	3,537
10/06	13%	6%	82%	4,004
10/07	20%	12%	68%	4,643
10/08	23%	13%	64%	5,014
10/09	25%	11%	65%	5,145
10/10	20%	11%	68%	4,774
10/11	20%	13%	67%	4,888
10/12	22%	15%	63%	5,004
10/13	24%	16%	59%	5,125
01/15	27%	17%	56%	5,300

Source: DAAIL. Active participants by setting. Numbers may not add up to 100 due to rounding.

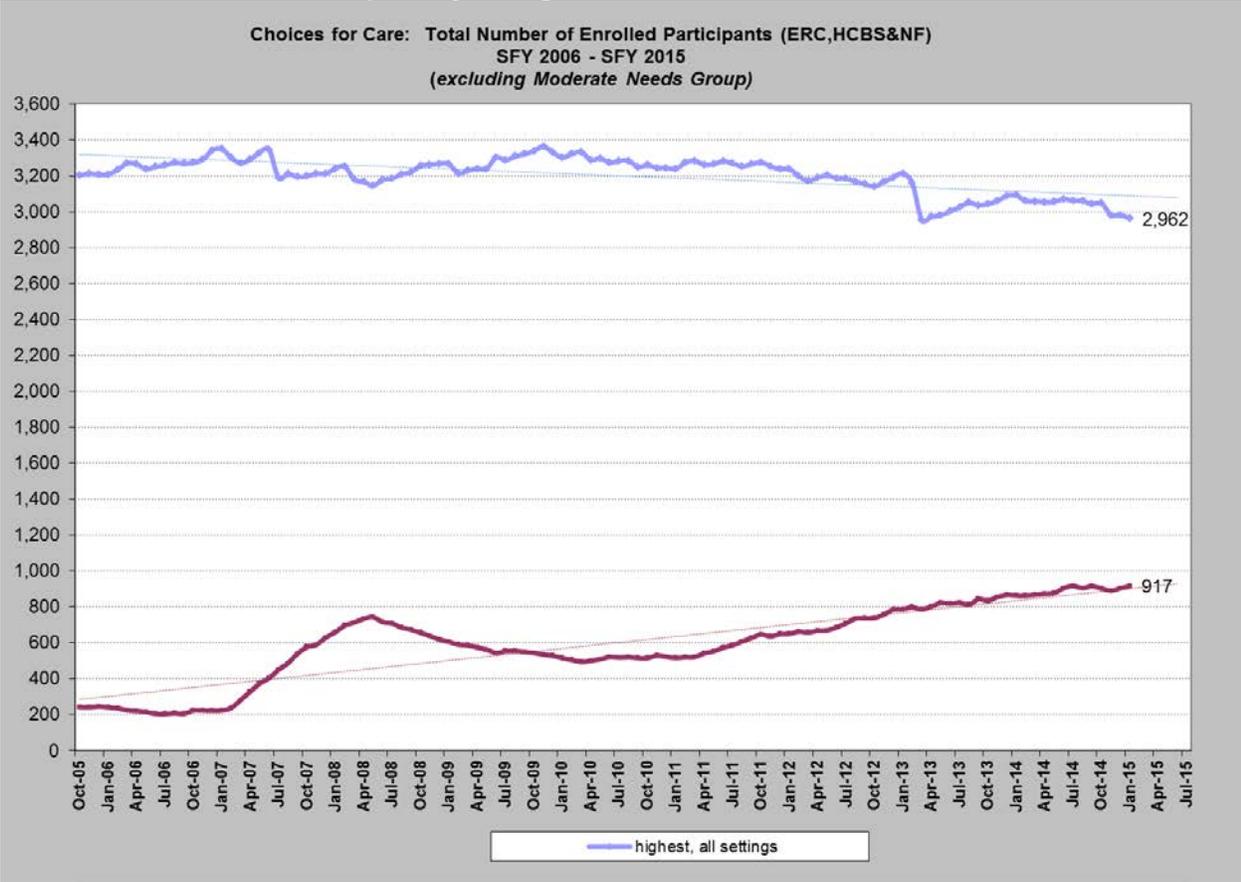
Since the beginning of CFC, Highest and High Need Group participants have been served in all three settings (NF, ERC and HCBS). Nursing facilities have been the setting that has served the greatest number of CFC participants. Even so, between 2005 and 2013 there was a rapid decline in nursing facility CFC enrollment which appeared to level off in 2014, when nursing facility enrollment dropped by only one percent from the previous year, from 49% to 48%. This trend was accompanied by a mere 1% increase in HCBS and a steady rate of 11% enrollment in ERC settings.

Point-in-Time Enrollment of Highest/High Participants by Setting

	NF	HCBS	ERC	Total High/ Highest
11/05	66	29	5	3,453
10/06	61	32	7	3,497
10/07	53	38	9	3,742
10/08	54	38	8	3,847
10/09	53	38	8	3,883
10/10	52	40	9	3,776
10/11	52	38	9	3,920
10/12	52%	38%	10%	3,903
10/13	49%	40%	11%	3,880
01/15	48%	41%	11%	3,879

Source: DAAIL. Numbers may not add up to 100 due to rounding.

Total Number of Enrolled Participants by Setting

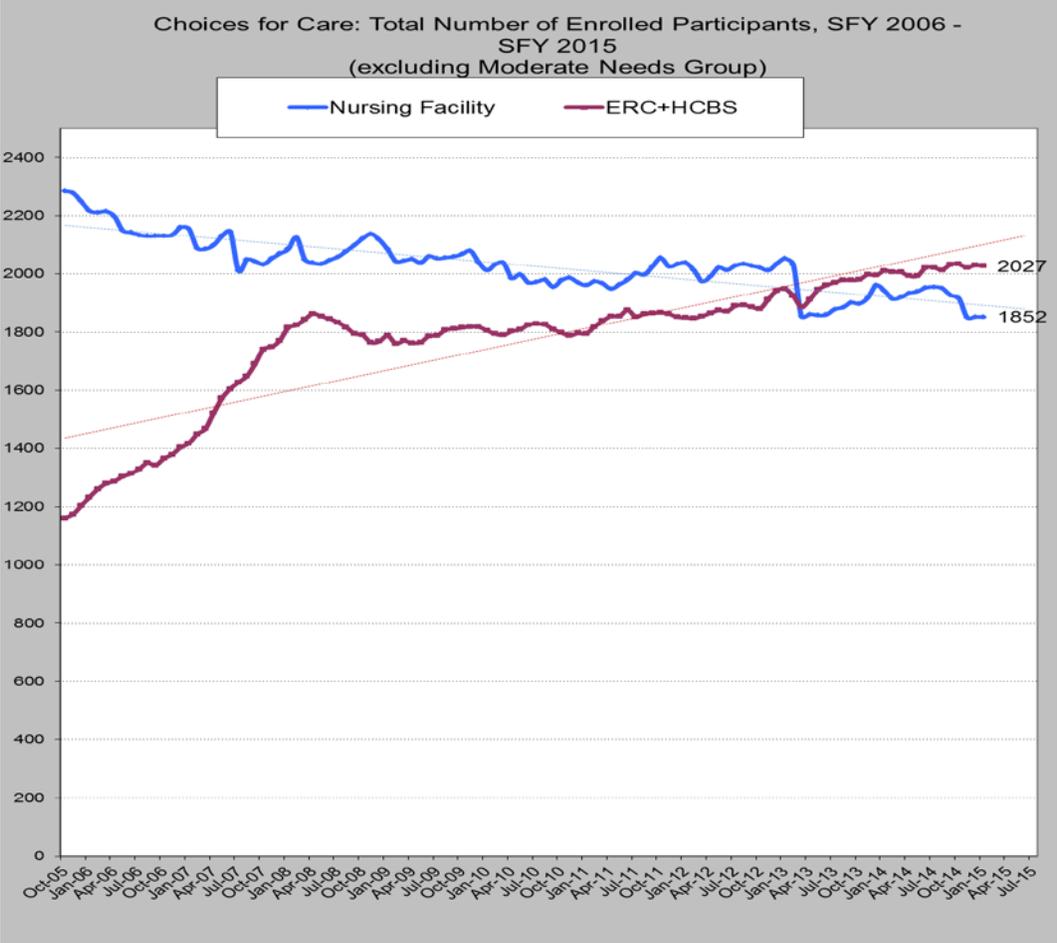


Source: DAIL /DDAS SAMS Database

CFC has increased its ability to serve participants in the community.

Over time, CFC has increased its ability to serve participants in the community. More participants are now being served in HCBS settings than in nursing facilities

Total Number of Enrolled Participants

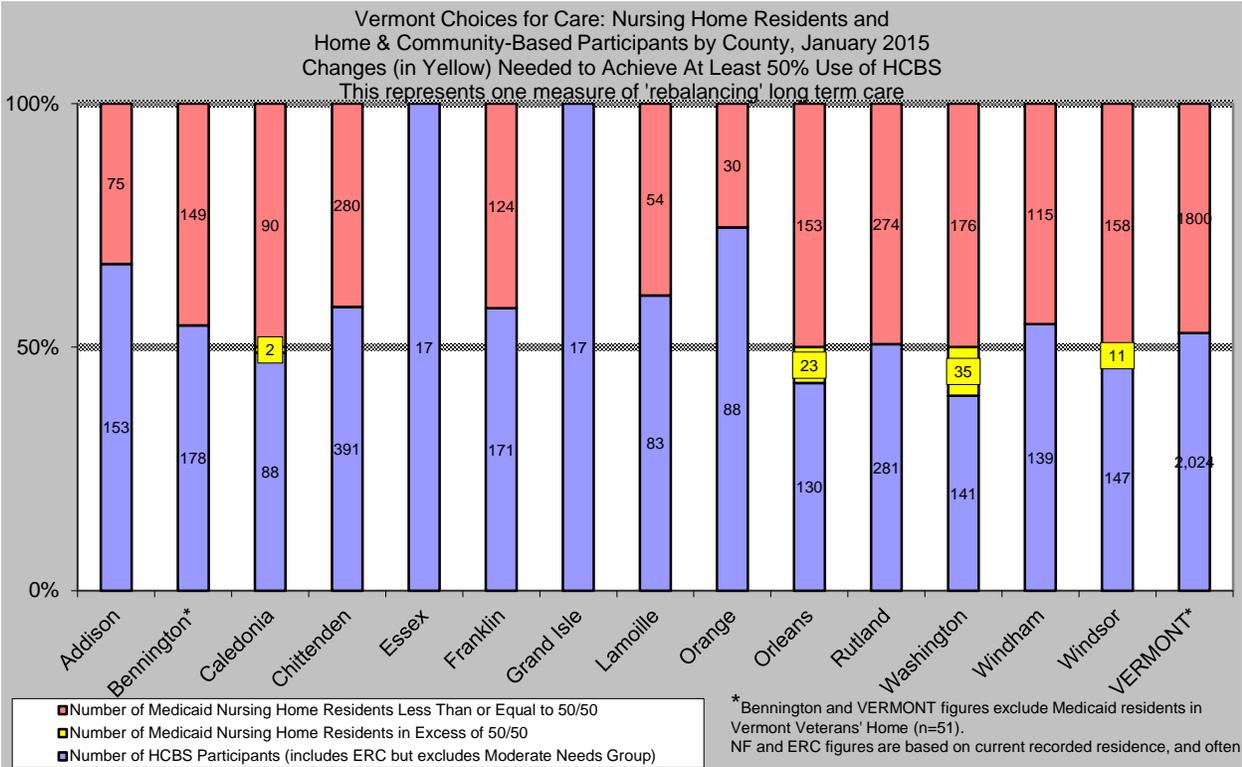


Source: DAIL /DDAS SAMS Database

Nursing Home Residents and HCBS Participants by County

As of January, 2015, ten of fourteen Vermont counties had surpassed the goal of a 50% balance between use of nursing facilities and HCBS and the percentage of nursing facility residents in Vermont as a whole had fallen to 47% of all CFC participants. By January, 2015, Vermont was 71 CFC participants away from achieving 50% balance in all counties. Overall, Vermont is succeeding in its goal of having more individuals receiving CFC services in a community setting. By September 2013, over 51% of CFC participants statewide received services in a HCBS setting.

Nursing Home Residents and HCBS Participants by County, January 2015



Source: DAIL /DDAS SAMS Database

1. Information Dissemination

1. Information Dissemination: CFC participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with participant’s expressed preferences and needs.			
Question 1.1: To what extent do participants receive information to make choices and express preferences regarding services and setting?	2014	Comparison to 2013	Comparison to 2006
1a. Percentage of HCBS participants rating “good” or above to “how would you rate how well people listen to your needs and preferences?”	89%	=	+
1b. Percentage of NF participants rating setting “good” or above to “meeting the resident’s choices and preferences”	87%	=	New
1b. Percentage of ERC participants rating setting “good” or above to “meeting the resident’s choices and preferences”	94%	=	New
2a. Percentage of HCBS participants responding to different answers to “how did you first learn about the long-term care services you receive?”*	Friend/Family/Word of Mouth/Other Children		23%
	Area Agency on Aging		22%
	Doctor, Nurse, health care provider		18%
	Home Health Agency		17%
	Hospital		11%
2b. Percentage of NF participants responding to different answers to “what is the most important reason you (or your family) chose this facility?”	Good Reputation		31%
	Hospital, Doctor, recommendation		16%
	Relative, friend recommendation		7%
3. Percentage of HCBS participants rating “good” or above to “how would you rate the amount of choice and control you had when you planned the services or care you would receive?”	81%	=	=
4. Percentage of HCBS participants who “agree” or above to “My current residence is the setting in which I choose to receive services”	95%	=	New

= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)
 - 2014 results worse (trend in a negative direction) New Measure is new; no comparison available
 * Qualitative, no comparisons are made

The information dissemination outcome is integral to CFC’s evaluation of the program as it allows an understanding of the avenues used by participants to obtain information about the program. HCBS, Nursing Facility (NF) and Enhanced Residential Care (ERC) participants have, as in the past, highly rated their “amount of choice and control”, with the overall trend remaining constant in comparison to the previous year.

HCBS participants and nursing facility and ERC participants stated that people listened to their needs. The ratings among HCBS participants remained positive and were consistent with the high ratings of the previous year as were ratings in specific programs including CFC personal care, Flexible Choices, homemaker and adult day center services. Nursing facility and ERC participants also rated highly the meeting of resident’s “choices and preferences.”

Percent of participants ratings of "good" or above		2006	2007	2008	2009	2010	2011	2012	2013	2014
1a. "How would you rate how well people listen to your needs and preferences?"	HCBS	86%	90%	90%	94%	91%	92%	91%	89%	89%
1b. "Meeting resident's choices and preferences"	NF	New						88%	89%	87%
1b. "Meeting resident's choices and preferences"	ERC	New						94%	94%	95%

Source: Thoroughbred Research Group and Vermont Health Care Association (VHCA)

Percent of participants ratings of "good" or above	2010	2011	2012	2013	2014
1a. "How would you rate how well people listen to your needs and preferences?"					
Personal Care	95%	92%	94%	92%	91%
Flexible Choices	85%	90%	91%	89%	89%
Homemaker Services	87%	89%	91%	84%	87%
Adult Day Center	90%	92%	91%	89%	89%
Adult Family Care	New				73%

Source: Thoroughbred Research Group

HCBS participants learned about their services from a variety of agencies and sources, with Friend/Family/Word of Mouth/Other Children and Area Agencies on Aging (AAA) emerging as the two most common sources (23% and 22% respectively), followed closely by a recommendation from a doctor, nurse, hospital or home health agency (18% and 17% respectively). Good reputation was by far the most common reason chosen for selection of a nursing facility, although doctor/nurse/hospital recommendation also played a meaningful role. The fact that only 4% of ERC/AL participants selected their facility based on the recommendation of the doctor/nurse/hospital may suggest an opportunity for DAIL and its partners to increase health providers' awareness of ERCs as a residential option. With the launch of its new website, DAIL further ensures that another easy to access and accessible information source is available to all. In addition, the use of the Universal Transfer Protocol currently being piloted in the Southwestern region of the state may help to encourage awareness of the ERCs and other community-based providers of long-term services and supports among health care providers.

Information resources/Reason for choosing facility	HCBS	NF	ERC
2a. Percentage of HCBS participants responding to different answers to "how did you first learn about the long-term care services you receive?" and 2b. Percentage of NF and ERC participants responding to different answers to "what is the most important reason you (or your family) chose this facility?"			
Family and Friends	23%	7%	13%
AAA	22%	N/A	N/A
Doctor, nurse, hospital recommendation	18%	16%	4%
Home Health Agency	17%	N/A	N/A
Good reputation of facility	N/A	31%	37%

Source: Thoroughbred Research Group and VHCA

Information dissemination also includes participants' ability to choose their settings and services. For HCBS participants, choice and control ratings have remained consistently higher than 80% over the last nine years. Similarly, residents'

ratings of the amount of choice and preference they are able to exert in nursing facilities and ERCs have remained stable during the two years it has been measured.

Percent of participants ratings of "good" or above		2006	2007	2008	2009	2010	2011	2012	2013	2014
3. "How would you rate the amount of choice and control you had when you planned the services or care you would receive?"	HCBS	86%	91%	89%	90%	81%	85%	84%	84%	81%
"Meeting residents choices and preferences"	NF								89%	87%
"Meeting residents choices and references"	ERC								94%	95%

Source: Thoroughbred Research Group and VHCA

An examination of the results for specific HCBS programs reveals differences in participants' ratings that are worth noting. In the case of participants in the Flexible Choices and Homemaker program, this year's ratings appear to reflect a trend in which ratings of "Amount of Choice and Control" increase one year over 80% and then decrease in another year. This year's ratings raises concern because they represent a larger decrease than previous years and appear counterintuitive as with the implementation of the Moderate Needs Group Flexible Funding program more options were made available for Homemaker participants. On the other hand, the LTSS Consumer Survey report noted that Moderate Needs participants receiving case management tend to rate certain items, including choice and control, significantly lower than other participants. These data suggest that the issue of "Amount of Choice and Control" may warrant ongoing monitoring by DAIL, particularly with regard to the MNG program including Flexible Choices and Homemaker services.

Percent of participants ratings of "good" or above	2010	2011	2012	2013	2014
3. "How would you rate the amount of choice and control you had when you planned the services or care you would receive?"					
Personal Care	84%	89%	87%	85%	84%
Flexible Choices	88%	80%	91%	88%	82%
Homemaker services	76%	81%	78%	81%	74%
Adult Day Center	81%	84%	88%	84%	81%
Adult Family Care*	New				73%

*Program had a low response rate and results should be interpreted with caution.

Source: Thoroughbred Research Group

The choice of setting measure continues to show a high percentage of HCBS participants agreeing that their current residence was the setting where they chose to receive care and services. The consistently high ratings by HCBS participants in Adult Day Centers further suggests that DAIL is succeeding in its goal to ensure that CFC participants receive services in a setting of their choice.

Percent of participants ratings of "agree" or above		2006	2007	2008	2009	2010	2011	2012	2013	2014
4. "My current residence is the setting in which I choose to receive services"	HCBS	New						89%	94%	95%

Source: Thoroughbred Research Group

Percent of participants ratings of "agree" or above	2013	2014
4. "Current residence is setting of choice"		
Personal Care	96%	96%
Flexible Choices	96%	97%
Homemaker services	93%	94%
Adult Day Center	90%	95%
Adult Family Care*	New	100%

*Program had a low response rate and results should be interpreted with caution.

Source: Thoroughbred Research Group

Overall, for information dissemination, CFC maintained gains. This year, Friend/ Family Word of Mouth and the AAAs continued to be important sources from which HCBS CFC participants learned about services. As noted in our recent policy brief, doctors and other healthcare providers also played a significant role, but clearly could do more. The Evaluation Team recommends that the ADRC and DAIL enhance current marketing and outreach to increase awareness of options. Ratings for choice and control in care planning among CFC HCBS participants also continue show room for improvement. Flexible Choices and Homemaker participants' ratings of choice and control decreased in comparison to other programs. This change should be monitored because Flexible Choices participants have historically rated f "choice and control" highly. For Homemaker participants, it may be that the introduction of a new service option was initially disruptive and over time, the positive impact will emerge. In either case, further examination is warranted.

2. Access

2. Access: CFC participants have timely access to long-term care supports in the setting of their choice.			
Question 2.1: Are people able to receive CFC services in a timely manner?	2014	Comparison to 2013	Comparison to 2006
5a. Percentage of HCBS participants rating "good" or above to "how would you rate the timeliness of your services?"	84%	=	=
5b. Percentage of NF participants rating setting "good" or above to "providing an adequate number of (nursing) staff to meet care needs"	68%	=	New
7a. Number of applicants "pending financial eligibility"**	478	319	New
7b. Number of applicants awaiting DAIL clinical eligibility**	90	113	New

Question 2.2: To what extent are CFC participants receiving the types and amount of supports consistent with their needs and preferences?	2014	Comparison to 2013	Comparison to 2006
8. Number and percentage of Long-term Care Ombudsman complaints from CFC HCBS participants regarding CFC service scope or amount**	80	118	—
9a. Percentage of HCBS CFC participants rating “good” or above to “how would you rate the degree to which the services meet your daily needs?”	89%	=	=
9b. Percentage of NF participants rating setting “good” or above to “meeting your need for grooming”	79%	=	New
9c. Percentage of NF participants rating setting “good” or above to “the competency of staff”	89%	=	New

= 2014 results not different (0-3% difference)

+

2014 results better (trend in a positive direction)

- 2014 results worse (trend in a negative direction)

New Measure is new; no comparison available

** Reverse coded = a lower number is a better result, while a higher number is a worse result

Access, as an outcome, focuses on the receipt of long-term support services in a timely-manner and the reflection of the needs and preferences of CFC participants. Also included as a measure of access is the timeliness of CFC participants' eligibility experience.

HCBS participants as a group rated the timeliness of their services consistently over the past four years (although there was a decrease from the high scores of Years 2-4). Personal Care, Homemaker and Adult day Center remained consistent with the previous year. However, Flexible Choices participants' ratings experienced a 5% decrease, a change which is unexpected.

For nursing facility participants, only 68% reported that there were adequate staff to meet their care needs. In comparison, national data shows 73% of respondents' rate facilities as having adequate staff. This is an area that could be further explored to identify opportunities for program improvement. This finding is in contrast to somewhat similar measures used to assess the sufficiency of care in the ERCs which showed that 94% of ERC residents felt that their health care needs and needs for personal assistance were met sufficiently in these settings.

Percent of participants ratings of “good” or “above:		2006	2007	2008	2009	2010	2011	2012	2013	2014
5a. “How would you rate the timeliness of your services?”	HCBS	84%	90%	89%	88%	84%	85%	83%	85%	84%
5b. “Providing an adequate number of (nursing) staff to meet care needs”	NF	New						66%	69%	68%
5b. “Sufficiency of health care needs”	ERC	New							96%	95%
5b. “Sufficiency of personal assistance”	ERC	New								94%

Source: Thoroughbred Research Group and VHCA

Percent of participants ratings of "good" or above	2010	2011	2012	2013	2014
5a. "How would you rate the timeliness of your services?"					
Personal Care	86%	89%	86%	88%	86%
Flexible Choices	92%	91%	88%	89%	86%
Homemaker services	84%	82%	80%	81%	82%
Adult Day Center	87%	82%	86%	86%	83%
Adult Family Care*	New	New	New	New	55%

*Program had a low response rate and results should be interpreted with caution.

Source: Thoroughbred Research Group

For 2014, we changed the wording of the question, "I receive all the services I need and want exactly when and how I need and want the services" to "I get the services I need the way I want to get them." We also changed the wording of the question about "when" services are received and added a separate question about where services are received.

Percent of participants ratings of "agree" or "above:		2014
6. "I get the services I need the way I want to get them."	HCBS	91%

Percent of participants ratings of "good" or "above:		2006	2007	2008	2009	2010	2011	2012	2013
6. "How would you rate when you receive your services or care?"	HCBS	86%	90%	90%	92%	88%	90%	88%	89%

Source: Thoroughbred Research Group

Percent of participants ratings of "good" or above	2010	2011	2012	2013
6. "How would you rate when you receive your services or care?"				
Personal Care	91%	91%	86%	91%
Flexible Choices	91%	93%	94%	91%
Homemaker services	84%	89%	86%	86%
Adult Day Center	85%	92%	91%	88%

Source: Thoroughbred Research Group

Percent of participants ratings of "agree" or above	2014
6. "Services are provided to me when I need them.	
Personal Care	92%
Flexible Choices	86%
Homemaker services	86%
Adult Day Center	88%
Adult Family Care*	73%

*Program had a low response rate and results should be interpreted with caution.

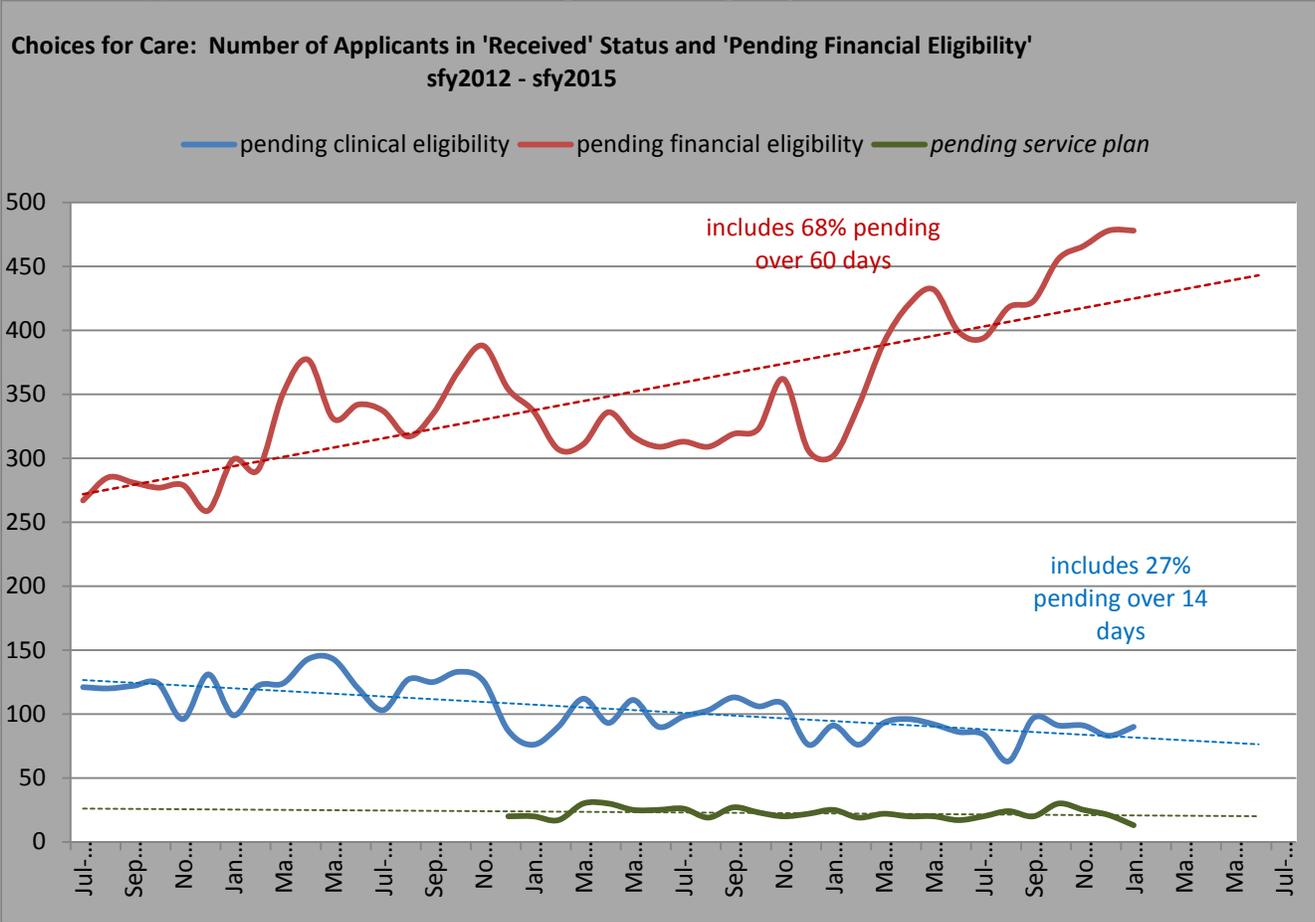
Percent of participants ratings of "agree" or above 6. "Services are provided to me where I need them.	2014
Personal Care	92%
Flexible Choices	86%
Homemaker services	90%
Adult Day Center	88%
Adult Family Care*	73%

CFC Participants were also asked about services they need, but cannot get and about a quarter of individuals receiving personal care, Flexible Choices, and adult day center services agreed that that they lacked needed services while about a third of participants receiving homemaker services agreed with this statement. No Adult Family Care participants agreed with this statement, but as noted previously, few AFC participants responded to the survey. When asked what specific services were needed that they could not get, participants' cited a wide array of services, ranging from needing more care and services generally to specific items such as better trained staff, transportation, wheelchairs and dentures and a variety of other services.

Percent of participants ratings of "agree" or above 6. "There are services I need but can't get".	2014
Personal Care	26%
Flexible Choices	27%
Homemaker services	33%
Adult Day Center	24%
Adult Family Care*	0%

Another aspect of access to CFC services is the timely processing of applications and eligibility determinations. DAIL implemented the Evaluators' 2014 recommendation to monitor the number of financial eligibility determinations which are completed in sixty days and the number of clinical eligibility determinations which are completed in fourteen days. This effort revealed that, as of January, 2015, 68%% of current applicants were waiting over sixty days for a financial eligibility determination, which represents a nearly threefold increase in the percent of individuals waiting approximately two months or more for a financial eligibility determination. Although federal rules permit a greater length of time for financial eligibility determinations, this increase is of great concern and warrants a close examination of the factors leading to such delays. In contrast, 27 percent of current applicants were waiting over fourteen days for a clinical determination.

Number of Applicants in "Received" and "Pending Financial Eligibility"



Source: Source: DAIL /DDAS SAMS Database

Although every state has an Ombudsman program, Vermont is one of twelve states which provide services to and collect data on complaints by HCBS participants to its Long-term Support Service Ombudsman Office. The use of this data is used to measure access and provides DAIL with information on some of the challenges participants encounter and assures participants that the CFC program strives to meet their needs

Over the years, the Ombudsman Office has refined its methodology for identifying complaints. Therefore, although we provided 2006 data, because it does not represent a complete year and is not using current methodology, we focus on data from 2011 through 2014. Based on the Ombudsman 2014 Annual Report (October 2013 through September 2014), a total of 80 complaints about HCBS were closed. This year's decrease in the number of complaints represents a positive change. Yet, because HCBS participants are often unaware of the role of the Ombudsman's office as a resource for resolving complaints, DAIL and the Ombudsman's Office may want to actively pursue opportunities to notify all CFC participants of the role of the that office. One strategy may be to work with the ADRC to train all Information and Referral staff, Option Counselors and individuals supporting the 211 service. In a subset of the complaints, those made about agencies or organizations that had five or more complaints against them included 34 complaints against Home Health Agencies, 4 against Economic Services, and 4 against the Vermont Department of Health Access. As in the past, the majority of Home Health Agency complaints were related to insufficient staff and difficulty filling hours, not being notified of schedule changes and lack of staff training, an issue also identified in the most recent Policy Brief. In 2014, 86% of complaints received were resolved satisfactorily.

8. HCBS Long-term Care Ombudsman complaints	2006	2011	2012	2013	2014
CFC HCBS complaint number	46*	107	99	118	80

Source: Long-Term Care Ombudsman

*Note: This number reflects the total number of complaints from HCBS consumers from April 2006 – September 2006. However, given that the Ombudsman Office changed its methodology for counting numbers of complaints, the number of complaints from HCBS consumers during this period is somewhat less.

This year, HCBS participants rated their services consistent with last year's high percentage regarding the degree to which services met their daily needs. Seventy-nine percent of nursing facility and ERC participants rated their settings positively for meeting their grooming needs which is consistent with last year but still shows room for improvement. In keeping with the goal of asking the same questions across the spectrum of care, the question of staff competency was asked of HCBS, NF and ERC participants. As a new measure, there is data to compare for 2014 and 2013. The data suggests that in this second year of results, personal care participants' ratings decreased by 4%, whereas NF and ERC participants' ratings were consistent with the ratings obtained in 2013.

Percent of participants ratings of "good" or above:		2006	2007	2008	2009	2010	2011	2012	2013	2014
9a. "How would you rate the degree to which the services meet your daily needs?"	HCBS	89%	91%	91%	95%	88%	88%	85%	89%	89%
9c. "Meeting your need for grooming"	NF	New						79%	80%	79%
9c. "The competency of staff"	NF	New						92%	91%	89%
	ERC	New							97%	94%

Source: Thoroughbred Research Group and VHCA

Percent of participants rating "good" or above to competency of staff:	2006	2007	2008	2009	2010	2011	2012	2013	2014
Personal Care				New				93%	93%
Flexible Choices				New				N/A	89%
Homemaker services				New				89%	87%
Adult Day Center				New				94%	92%
Adult Family Care				New					100%

Source: Thoroughbred Research Group

This year, many of the measures related to access have results which are consistent with the previous year. The number of complaints to the Ombudsman Office decreased this year. On the other hand, staff competency in Adult Day centers with a 10% decrease emerged as a possible area for improvement and the 4% decrease in the rating for personal care warrants monitoring.

3. Effectiveness

3. Effectiveness: Participants receive effective HCBS to enable participants to live longer in the community.			
Question 3.1: Is CFC increasing in its ability to serve participants in all CFC levels of need in the community?	2014	Comparison to 2013	Comparison to 2006
10. Number of individuals on waiting list for high needs**	0	=	+
11. Percentage of CFC participants residing in nursing facilities out of total CFC participants in the highest and high levels of need		49%	+
12. Number of licensed nursing home beds**	3115	3,237	+
13. For CFC participants in the highest, high, and moderate need levels living in the community, percentage of participants rating "good" or above to "how would you rate the degree to which the services meet your daily needs?" (NOTE: Data began to be collected in 2010.)	Personal Care	92%	=
	Flexible Choices	86%	-
	Homemaker services	83%	=
	Adult Day Center	90%	=
	Adult Family Care	100%	New
Question 3.2: To what extent are participants' long-term care supports coordinated with all services?	2014	Comparison to 2013	Comparison to 2006
14. Percentage of HCBS participants reporting "almost always" or above to "I feel I have a part in planning my care with my case manager or support coordinator"	86%	=	New
15. Percentage of HCBS participants reporting "almost always" or above report to "my case manager or support coordinator coordinates services to meet my needs"	85%	=	New
Question 3.3: To what extent does Medicaid nursing facility residents' acuity change over time?	2014	Comparison to 2013	Comparison to 2006
16. Case Mix Acuity	1.098	1.095	+

= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)
 - 2014 results worse (trend in a negative direction) New Measure is new; no comparison available
 ** Reverse coded = a lower number is a better result, while a higher number is a worse result

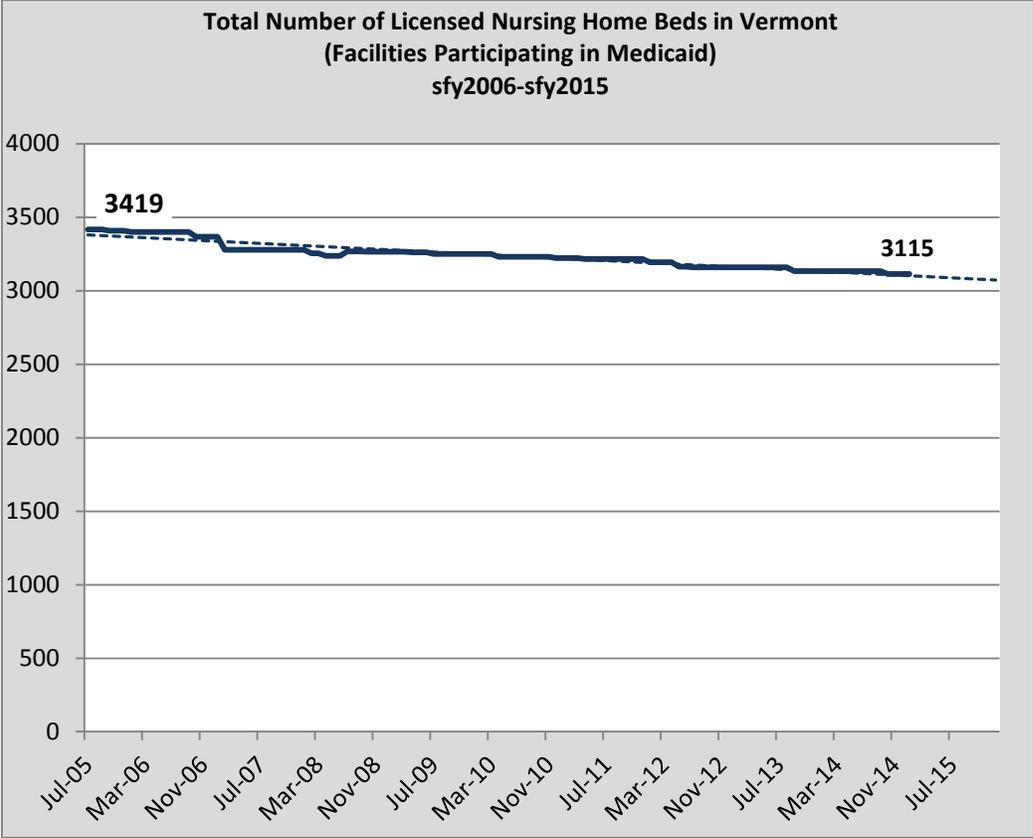
Effectiveness is another measure which allows DAIL to assess the extent to which the CFC program meets its goal of providing services to participants in the setting of their choice. The measure also provides information on whether CFC services are coordinated with other services.

11. Percentage of CFC Highest and High Needs participants by setting	NF	HCBS	ERC
11/05	66%	29%	5%
10/06	61%	32%	7%
10/07	53%	38%	9%
10/08	54%	38%	8%
10/09	53%	38%	8%
10/10	52%	40%	9%
10/11	52%	38%	9%
10/12	52%	38%	10%
10/13	49%	40%	11%
10/14	49%	40%	11%
1/15	48%	41%	11%

Source: DAIL

In the ninth year of the program, there continued to be no waiting/applicant list for participants in the high needs group and an increasing percentage of Highest and High Needs Group participants were served in the community. This year, less than 50% of participants were served in nursing facilities, which is a meaningful accomplishment. The figure on the next page shows that there is a positive trend in the number of licensed beds which decreased from 3,419 in 2005 to 3,115 in 2014. Despite this decline, the statewide occupancy rate was 86% in the beginning of 2015 meaning that there was still excess capacity (DAIL, 2015).

14. Number of licensed Nursing Facility Beds



Source: Vermont Division of Ratesetting.

This year, participants' ratings of services as meeting their daily needs remained the same as in the previous year at 89%. Ratings on this measure by Flexible Choices participants declined, whereas ratings by participants in Personal Care services, Homemaker services and Adult Day Centers remained constant in comparison to the previous year. As this year's overall and specific program ratings primarily remained the same, the decrease of 11% for participants in the Flexible Choice program suggests that a more in-depth review of the experiences of these participants is needed.

Percent of participants ratings of "good" or above		2006	2007	2008	2009	2010	2011	2012	2013	2014
13. "How would you rate the degree to which the services meet your daily needs?"	HCBS	89%	91%	91%	95%	88%	88%	85%	89%	89%

Source: Thoroughbred Research Group

Percent of participants ratings of "good" or above	2010	2011	2012	2013	2014
13. "How would you rate the degree to which the services meet your daily needs?"					
Personal Care	92%	93%	90%	92%	92%
Flexible Choices	90%	90%	98%	93%	86%
Homemaker services	85%	86%	79%	86%	83%
Adult Day Center	83%	87%	83%	88%	90%
Adult Family Care*	New				100%

*Program had a low response rate and results should be interpreted with caution.

Source: Thoroughbred Research Group

In 2012, new measures were added to assess coordination of services, an important aspect of effectiveness. In the third year of these measures, ratings were consistent overall despite a lower rating by participants in the Flexible Choices program and a modest increase for participants in the homemaker services. With the Flexible Choices rating decreased from 100% last year to 78% this year, it will be important that DAIL further investigate the factors which may have contributed to the change. Overall, these results suggest there may be room for improvement related to person-centered planning, particularly for Homemaker services and Adult Day Centers. It will be important to monitor if there are improvements in this area as a result of proposed changes that will allow individuals in the Moderate Needs Group to select a flexible service option.

Percent of participants ratings of "Almost always" or above:		2006	2007	2008	2009	2010	2011	2012	2013	2014
14. "I feel I have a part in planning my care with my case manager or support coordinator"	HCBS							86%	83%	86%

Source: Thoroughbred Research Group

Percent of participants ratings of "almost always" or above	2012	2013	2014
14. "I feel I have a part in planning my care with my case manager or support coordinator"			
Personal Care	89%	88%	87%
Flexible Choices	NA	100%	86%
Homemaker services	81%	78%	83%
Adult Day Center	88%	83%	85%
Adult Family Care*	New		100%

*Program had a low response rate and results should be interpreted with caution. Source: Thoroughbred Research Group
 With three years of data, HCBS participants rating of their case manager/support coordinator in terms of coordinating care to meet needs remained consistent. Individual program data also remained consistent from 2013 to 2014 with the exception of a decrease from 100% to 93% by Flexible Choices participants.

Percent of participants ratings of "almost always" or above:		2006	2007	2008	2009	2010	2011	2012	2013	2014
15. "My case manager or support coordinator coordinates services to meet my needs"	HCBS	New						88%	85%	85%

Source: Thoroughbred Research Group

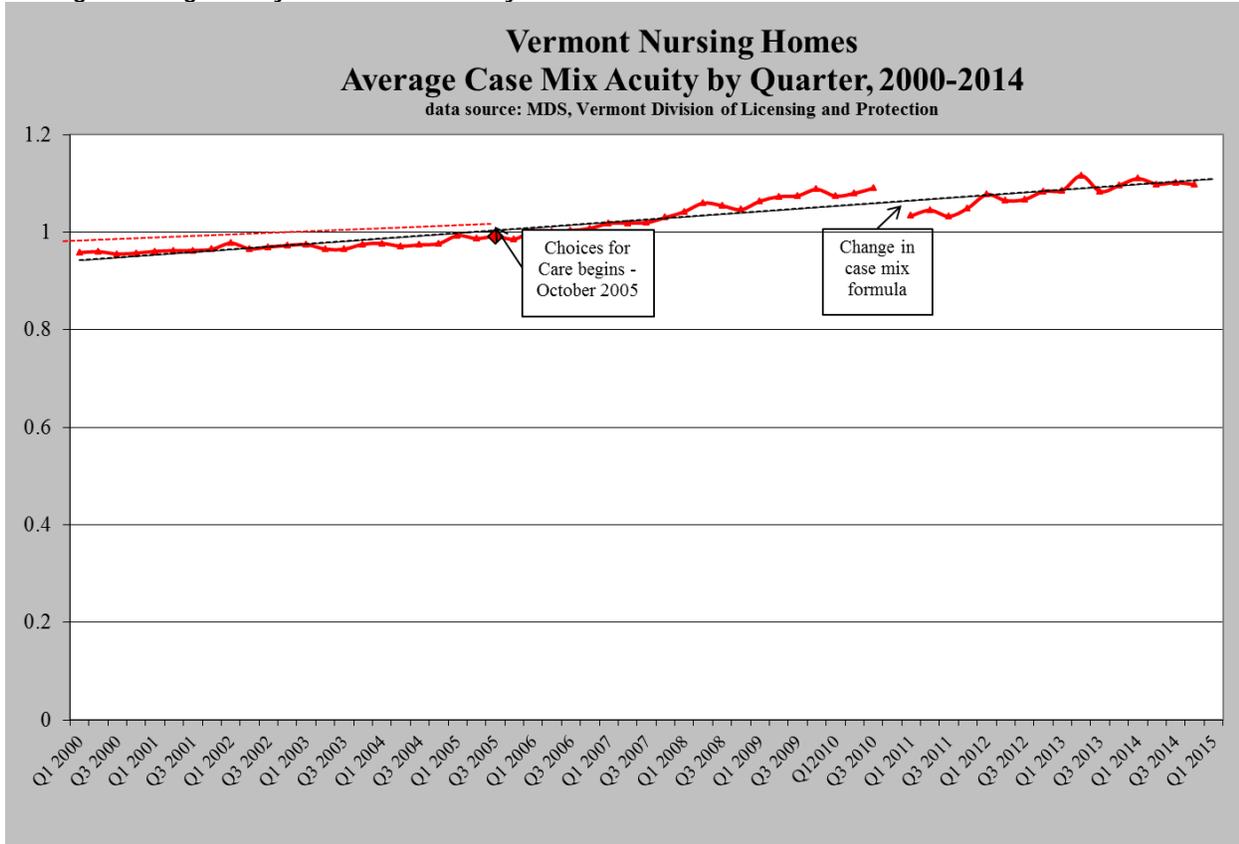
Percent of participants ratings of "good" or above	2013	2014
15. "My case manager or support coordinator coordinates services to meet my needs"		
Personal Care	89%	88%
Flexible Choices	100%	93%
Homemaker services	80%	81%
Adult Day Center	86%	87%
Adult Family Care*	New	100%

*Program had a low response rate and results should be interpreted with caution.

Source: Thoroughbred Research Group

In terms of case mix acuity for nursing facilities, acuity levels have been increasing over time. Between 2006 and 2010, there was a 7.7% increase in the case mix acuity. In 2011, there was a change in score types due to Vermont's changing from RUG III to RUG IV. These changes do not allow for comparisons between recent and prior years. Between 2011 and the 4th quarter of 2014, there was a 6.2% increase in case mix acuity. This represents a somewhat slower rate of growth than in past years. . The Evaluation Team would like to work with DAIL to further refine measures related to Case Mix Acuity. Because of the large number of RUG IV levels, it would be more relevant to look at the specific levels related to Activities of Daily Living (ADLs). This will better enable the Evaluation Team to determine if the functional needs of nursing facility residents are increasing over time as more individuals are choosing community-based settings.

Average Nursing Facility Case Mix Scores by Quarter



Source: Minimum Data Set, Vermont Division of Licensing and Protection.

Overall, CFC continues to be effective in its ability to serve participants in the community. Recognizing that programs may not be able to sustain a 100% rating each year, the decreased rating by Flexible Choices participants as it concerns “services meeting your daily needs” is an area that may warrant some further examination as it concerns an essential aspect of the CFC program.

4. Experience with Care

4. Experience with Care: Participants have positive experiences with the types, scope, and amount of CFC services.			
Question 4.1: To what extent do CFC participants report positive experiences with types, amount and scope of CFC services?	2014	Comparison to 2013	Comparison to 2006
17a. Percentage of HCBS participants rating “good” or above to “how would you rate the overall quality of the help you receive?”	89%	=	=
17b. Percentage of NF participants rating setting “good” or above on “the quality of care provided by the (nurses)/staff”	90%	=	New
17c. Percentage of NF participants rating setting “good” or above on “the quality of care provided by the nursing assistants”	88%	=	New
18a. Percentage of HCBS participants rating “good” or above on “How would you rate the courtesy of those who help you?”	96%	=	=

4. Experience with Care: Participants have positive experiences with the types, scope, and amount of CFC services.			
Question 4.1: To what extent do CFC participants report positive experiences with types, amount and scope of CFC services?	2014	Comparison to 2013	Comparison to 2006
18b. Percentage of NF participants rating setting "good" or above on "the staff's care and concern for you"	88%	=	New
18b. Percentage of ERC participants rating setting "good" or above on "the staff's care and concern for you"	96%	=	New
20a. Percentage of HCBS participants who reported experiencing "any problems with services during the past 12 months" (NOTE: Data were only available for 2010-2014.)	Personal Care	16%	=
	Flexible Choices	6%	+
	Homemaker services	23%	=
	Adult Day Center	5%	+
	Adult Family Care	0%	New
20b. Percentage of HCBS participants who reported experiencing "any problems with services during the past 12 months" who reported that staff worked "to resolve any problems" (NOTE: Data were only available for 2010-2014.)	Personal Care	59%	=
	Flexible Choices	24%	-
	Homemaker services	62%	+
	Adult Day Center	49%	-
	Adult Family Care	0%	New
20c. Percentage of NF participants rating setting "good" or above on "management's responsiveness to your suggestions and concerns"	81%	=	
Percentage of ERC participants rating setting "good" or above on "management's responsiveness to your suggestions and concerns"	94%	=	
21a. Percentage of HCBS participants reporting "somewhat satisfied" or above to "how satisfied are you with the services you receive?" (NOTE: Data were only available for 2010-2014.)	Personal Care	95%	=
	Flexible Choices	92%	=
	Homemaker services	93%	=
	Adult Day Center	94%	=
	Adult Family Care	100%	New
21b. Percentage of NF participants rating setting "good" or above on "how would you rate your overall satisfaction?"	87%	=	New

4. Experience with Care: Participants have positive experiences with the types, scope, and amount of CFC services.			
Question 4.1: To what extent do CFC participants report positive experiences with types, amount and scope of CFC services?	2014	Comparison to 2013	Comparison to 2006
Percentage of ERC participants rating setting "good" or above on "how would you rate your overall satisfaction?"	96%	=	New
=	2014 results not different (0-3% difference)		+ 2014 results better (trend in a positive direction)
-	2014 results worse (trend in a negative direction)		New Measure is new; no comparison available
**	Reverse coded = a lower number is a better result, while a higher number is a worse result		

Experience with care relates to quality and satisfaction outcomes. In addition, measures include courtesy and problem resolution. Taken in total, these measures assess whether or not CFC participants had positive experiences with CFC services.

Participants across all settings (HCBS, nursing facility and ERC) continued to rate quality of help/care as high. Ratings for nursing facilities were as high as 90% while the ERCs achieved a 94% satisfaction rating for meeting healthcare needs and sufficiency of personal assistance. For specific HCBS programs, Flexible Choices and Adult Day Center ratings were lower this year yet still higher than 90% and Homemaker services continue to lag slightly behind other programs with a ratings of 86%. In its first year of operation, the rating for Adult Family Care was very low; however, as there were very few respondents, this rating should be interpreted with caution, as noted in the footnote to the table. Even so, this and other results suggest a need for ongoing monitoring of Family Care.

Percent of participants ratings of "good" or above:		2006	2007	2008	2009	2010	2011	2012	2013	2014
17a. "How would you rate the overall quality of the help you receive?"	HCBS	92%	94%	93%	97%	89%	93%	90%	91%	89%
17b. "The quality of care provided by the (nurses)/staff"	NF	New						90%	93%	90%
17c. "The quality of care provided by the nursing assistants"	NF	New						93%	90%	88%
"Sufficiency of healthcare needs"	ERC	New						95%	96%	95%
Sufficiency of personal assistance"		New						95%	97%	94%

Source: Thoroughbred Research Group and VHCA

Percent of participants ratings of "good" or above	2010	2011	2012	2013	2014
17a. "How would you rate the overall quality of the help you receive?"					
Personal Care	97%	97%	93%	92%	91%
Flexible Choices	88%	91%	98%	92%	89%
Homemaker services	89%	90%	87%	87%	86%
Adult Day Center	94%	95%	95%	91%	89%
Adult Family Care*	New				55%

*Program had a low response rate and results should be interpreted with caution

Source: Thoroughbred Research Group

HCBS, NF and ERC participants continued to rate highly the “courtesy of those who help you” and “staff’s care and concern for you”. This high rating was also reflected in this year’s specific program, further supporting HCBS, NF and ERC participants’ positive experience with CFC. CFC participants also gave high ratings for courtesy and concern in HCBS, nursing facility and ERC settings over time. Ratings over 90% over the past eight years show a very positive experience with CFC.

The ratings for each program also continued to be high, although the rating for the Homemaker program dipped from 96% to 90%.

Percent of participants ratings of “good” or above:		2006	2007	2008	2009	2010	2011	2012	2013	2014
18a. “How would you rate the courtesy of those who help you?”	HCBS	97%	98%	98%	97%	96%	94%	96%	96%	96%
18b. “The staff’s care and concern for you”	NF	New						91%	91%	97%
	ERC	New							94%	96%

Source: Thoroughbred Research Group and VHCA

Percent of participants ratings of “good” or above:	2010	2011	2012	2013	2014
18a. “How would you rate the courtesy of those who help you?”					
Personal Care	97%	98%	97%	96%	95%
Flexible Choices	91%	93%	99%	95%	95%
Homemaker services	95%	96%	95%	96%	90%
Adult Day Center	95%	97%	97%	96%	93%
Adult Family Care	New				73%

Source: Thoroughbred Research Group

The resolution of problems is another aspect of experience with care. Eighty-seven percent of all HCBS respondents rated how well concerns or problems are resolved as “good” or above (consistent with the 2013 response of 86%). Consistency of rating was also shown by NF participants as they rated “management’s responsiveness to suggestions and concerns” at 81% in 2014 and 82% in 2013. The overall ratings for CFC participants suggest that across settings problems are readily resolved.

A review of the specific programs permits a more complete understanding of where problems exist, the types of problems, and whether those problems were resolved. The percentage of Flexible Choices and Adult Day Center participants who responded that they had “a problem with services in the last 12 months” fell substantially whereas, the percentage of Personal Care and Homemaker participants remained consistent with the 2013 percentages.

Respondents were given a chance to describe the difficulties they experienced in open-ended responses; the most commonly identified problems were:

- Personal Care participants: staff dependability, staff skills/training, communication problems;
- Flexible Choices participants: Adult Day Center requirements, delayed budget review difficulties, aid hired misrepresented skills and unable to do required tasks;
- Homemaker participants: staff skills/training, staff dependability, staff rudeness/disrespectfulness;

- Adult Day Center participants: Lack of choice and control, staff skills/training, reduction in services.

Even though the overall percentage of CFC participants responding that they “experienced a problem in the last 12 months” is relatively small in 3 out of the 4 programs, it is worth noting that issues related to “staff skills/training” were consistently identified as a problem, just as they were in interviews of CFC participants, family members and case managers that we did for the 2015 policy brief, which underscores the need for DAIL to address this issue. States such as Massachusetts have developed evidence-based on-line training for direct care workers and this could be a resource which DAIL may find useful to explore with CFC stakeholders.

In addition, it appears that rates of satisfactory resolution of problems were relatively low. This may be another issue that DAIL might find useful to examine going forward.

20a. HCBS Problems Reported (Rep.) and Resolved (Res.)	2010		2011		2012		2013		2014	
	Rep.	Res.								
Personal Care	16%	67%	11%	53%	14%	62%	15%	59%	16%	59%
Flexible Choices	19%/	32%	15%	22%	26%	67%	20%	49%	6%	24%
Homemaker services	28%	68%	17%	62%	24%	50%	24%	55%	23%	62%
Adult Day Center	10%	52%	6%	48%	5%	80%	12%	73%	5%/	49%
Adult Family Care	New								0%	0%

Source: Thoroughbred Research Group

Over time, CFC participants have given high ratings of “satisfaction” across all settings and the ratings in 2014 were consistent with this trend. Finally, satisfaction represents a global measure of experience. Across all settings and services, satisfaction was high in 2014 and over time.

Percentage of HCBS participants ratings “somewhat satisfied” or above 21a. and 21b. “Satisfaction with services”	2010	2011	2012	2013	2014
Personal Care	98%	99%	96%	95%	95%
Flexible Choices	97%	94%	96%	94%	92%
Homemaker services	94%	93%	92%	90%	93%
Adult Day Center	96%	97%	95%	94%	94%
Nursing Facility	New		89%	89%	87%
Enhanced Residential Care	New		96%	96%	93%

Source: Thoroughbred Research Group and VHCA

CFC mostly maintained positive gains in terms of quality, courtesy and satisfaction. However, there remains a potential issue around the percent of HCBS participants experiencing challenging with resolving problems within specific services.

5. Quality of Life

5. Quality of Life: Participants’ reported that their quality of life improves.				
Question 5.1: To what extent does CFC participants’ reported quality of life improve?	2014	Comparison to 2013	Comparison to 2010***	
22. Percentage of HCBS CFC participants reporting “somewhat better” or	Personal Care	91%	=	=

above to "Has the help you receive made your life...?"	Flexible Choices	94%	-	+
	Homemaker services	86%	=	=
	Adult Day Center	85%	=	=
	Adult Family Care	83%	New	
23a. Percentage of HCBS participants reporting "somewhat" or above to "I am satisfied with how I spend my free time"		72%	+	=
23b. Percentage of NF participants rating setting "good" or above on "offering you meaningful activities"		83%	-	New
23b. Percentage of ERC participants rating setting "good" or above on "offering you meaningful activities"		86%	=	New
23c. Percentage of HCBS participants reporting "somewhat" or above to "I have someone I can count on to listen to me when I need to talk"		83%	=	=
23d. Percentage of NF participants rating setting "good" or above on "meeting your religious and spiritual needs"		88%	=	New
23e. Percentage of ERC participants rating setting "good" or above on "meeting your religious and spiritual needs"		85%	=	New
23f. Percentage of HCBS participants reporting "somewhat" or above to "I feel satisfied with my social life"		60%	+	=
23g. Percentage of NF participants rating setting "good" or above on "offering you opportunities for friendships with other residents"		88%	-	New
23h. Percentage of ERC participants rating setting "good" or above on "offering you opportunities for friendships with other residents"		91%	-	New
23i. Percentage of HCBS participants reporting "somewhat" or above to "I have someone I can count on in an emergency"		89%	=	=
23i. Percentage of HCBS participants reporting "somewhat" or above to "I feel prepared for an emergency"		70%	New	New
23j. Percentage of NF participants rating setting "good" or above on "offering you opportunities for friendships with staff"		90%	=	New
23k. Percentage of ERC participants rating setting "good" or above on "offering you opportunities for friendships with staff"		92%	=	New
23l. Percentage of HCBS participants reporting "somewhat" or above to "I feel safe in the home where I live"		90%	=	=
23m. Percentage of NF participants rating setting "good" or above on "how safe it is for you"		93%	=	New
23n. Percentage of ERC participants rating setting "good" or above on "how safe it is for you"		97%	=	New
24. Percentage of HCBS participants who "agree" or above to "My services help me to achieve my personal goals"		90%	-	New

= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)
 - 2014 results worse (trend in a negative direction) New Measure is new; no comparison available

*** Methodology changed and earlier results not comparable

Quality of life encompasses several domains including meaningful activities, relationships, and safety. Ratings for most measures for HCBS participants were high, with the notable exception of questions measuring satisfaction with one's social life and with how one spends one's free time. These ratings were quite low (60% and 72%, respectively) and are a

cause for concern. Ratings on nursing facilities and ERC measures such as the availability of meaningful activities and opportunities for friendships with residents and staff were consistently high.

HCBS participants rating of whether the help they received made their lives better remained consistently high. In addition, all CFC HCBS programs had consistently high ratings for this measure. In contrast, HCBS participants' assessment of whether the program helped them to achieve their personal goals was low (70%), which raises questions about how closely principles of person-centered planning are followed within the HCBS program.

Because safety is an important component of quality of life, a question was added this year – "I feel prepared for an emergency." Only 70% of HCBS participants responded in the affirmative to this question. This finding contrasts with participants' answer to the related question, "I have someone to count on in an emergency" to which 89% of HCBS participants responded positively. These findings suggest that although participants believe that they have someone who would assist them in an emergency, they do not have a firm plan for how they would respond in an emergency.

Percent of HCBS participants ratings of "somewhat better" or above:	2006	2007	2008	2009	2010	2011	2012	2013	2014
22. "Has the help you receive made your life...?"	94%	91%	91%	94%	92%	94%	88%	91%	89%

Source: Thoroughbred Research Group

Measures were chosen to allow for comparisons among and between HCBS and nursing facilities and ERCs; however, direct comparisons are not possible as questions vary across surveys. After having remained relatively stable for several years, HCBS quality of life measures declined substantially in all domains, except feeling safe in one's home.

Percent of HCBS participants ratings of "somewhat agree" or above with the following statements	2010	2011	2012	2013	2014
23a. "I am satisfied with how I spend my free time"	89%	90%	69%	65%	72%
23c. "I have someone I can count on to listen to me when I need to talk"	94%	95%	85%	81%	83%
23e. "I feel satisfied with my social life"	81%	83%	58%	53%	60%
23g. "I have someone I can count on in an emergency"	94%	97%	91%	95%	89%
23i. "I feel safe in the home where I live"	98%	97%	90%	89%	90%

Source: Thoroughbred Research Group

Nursing facility ratings were consistent with last year's ratings in 3 out of 5 domains; however, there were modest declines in the rating for meaningful activities and opportunity for friendships with other residents.

Percent of NF participants ratings of "good" or above with the following statements	2010	2011	2012	2013	2014
23b. "Offering you meaningful activities."		New	84%	88%	83%
23d. "Meeting your religious and spiritual needs"		New	88%	89%	88%
23f. "Offering you opportunities for friendships with other residents"		New	88%	92%	88%
23h. "Offering opportunities for friendships with staff"		New	91%	90%	90%
23j. "How safe it is for you"		New	92%	92%	93%

For the second year in a row, there was an overall increase in participants (83% to 90%) agreeing that services help to achieve personal goals. An increase was seen for all of the specific programs.

Percent of participants ratings of "agree" or above	2006	2007	2008	2009	2010	2011	2012	2013	2014
24. "My services help me to achieve my personal goals"	New						75%	83%	90%

Source: Thoroughbred Research Group

Percent of participants ratings of "good" or above 24. "My services help me to achieve my personal goals"	2013	2014
Personal Care	86%	91%
Flexible Choices	84%	90%
Homemaker services	79%	88%
Adult Day Center	85%	90%
Adult Family Care*	New	73%

*Program had a low response rate and results should be interpreted with caution.

Source: Thoroughbred Research Group

The continued increase in participants' assessment that CFC services help them to achieve their personal goals demonstrate the positive impact that CFC has on the lives of the people it serves and the generally positive ratings among NF facility residents do the same. Even so, the sharp decline on measures pertaining to the social lives of HCBS recipients represents a significant opportunity for improvement. In our recent policy brief, we recommended that the independent living assessment and care plan processes be revised to take a more person-centered planning approach. As part of these revised processes, these findings suggest that careful attention should be paid to enhancing the social lives of CFC participants.

6. Waiting List

6. Waiting List: CFC applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g. nursing facility, enhanced residential care, and home care).			
Question 6.1: In the presence of an active waiting list, to what extent does the implementation of a waiting list for the High Needs group in Choices for Care have different impact on applicants waiting to access home and community-based services versus nursing facility services?	2014	Comparison to 2013	Comparison to 2006
25. Percentage of CFC applicants on the High Needs waiting list who are waiting for HCBS, compared with applicants waiting for ERCs, and nursing facilities**	No waiting list	=	+

= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)
 - 2014 results worse (trend in a negative direction) New Measure is new for 2014; no comparison available

High Needs participants have not been subject to a waiting/applicant list since 2011. As a result, this outcome is not applicable as expressed. Without a waiting/applicant list for High Needs participants, CFC achieves its goal of serving all High Needs participants with equal access to services regardless of the setting of their choice.

In contrast, the Moderate Needs Group program does have a waiting list. While not specifically an outcome in the revised evaluation plan, the Evaluation Team presents data on these waiting lists to CFC so CFC can monitor this group. As of

January 2015, there were 449 on the Moderate Needs Group waiting list. CFC continues to have positive outcomes for the High Needs Group waiting (applicant) list, but waiting (applicant) lists when allocated dollars to providers are unspent for Moderate Needs Group remain a concern.

7. Budget Neutrality

7. Budget Neutrality: Medicaid cost of serving CFC participants is equal to or less than the cost to provide Medicaid services without the Demonstration.					
Question 7.1: Are the total costs of serving CFC participants less than or equal to the projected maximum costs for serving this population in the absence of the waiver?			2014	Comparison to 2013	Comparison to 2006
27. Total annual CFC expenditures by setting	HCBS (including ERC)	\$59,370,598	28.9%	=	New
	Nursing facility	\$118,298,502	57.7%	=	New
	Acute	\$27,491,139	13.4%	=	New
27. Percentage of Medicaid expenditures for nursing facilities for Highest and High Needs participants in comparison with Medicaid community services for all participants			66.6%	=	New
28. Total appropriations versus actual expenditures			The Long Term Care portion of the Choices for Care budget was under budget by \$5,593,331 thru the end of SFY14.		
29. How surplus was reinvested*			SY2014 unobligated funds (\$3,078,908) are proposed to be reinvested in the following main categories: <ul style="list-style-type: none"> • Providing funds for Support and Services at Home (SASH) • Providing funds for home modifications • Address Moderate Needs group waitlist 		

New Measure is new; no comparison available * Qualitative, no comparisons are made

Since the inception of CFC, the Vermont legislature has appropriated dollars for the program, allowing the state to provide services to participants in their chosen setting. CFC has maintained its budget neutrality and spent below appropriations.

DAIL strategically reinvested its unobligated funds to improve funding for home care, home modifications and for the Moderate Needs Group waiting (applicant) lists. This was accomplished by:

- Increasing funding for Support and Services at Home (SASH)
- Increasing funding for home modifications
- Addressing Moderate Needs Group waiting lists.

CFC met budget neutrality requirements, while reinvesting unobligated funds ('savings') strategically.

8. Health Outcomes

8. Health Outcomes: CFC participants' medical needs are addressed to improve self-reported health.			
Question 8.1: To what extent are CFC participants' medical needs addressed to improve self-reported health?	2014	Comparison to 2013	Comparison to 2006
30. Percentage of HCBS participants whose rating of their general health is "good" or better (NOTE: Data were only available for 2008-2014.)	48%	=	=
31. Percentage of HCBS participants who "agree" or above to "My services help me to maintain or improve my health"	93%	+	New
32. Percentage of HCBS participants reporting "almost always" or above to "My case manager or support coordinator understands which services I need to stay in my current living situation"	87%	=	New

= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)
 - 2014 results worse (trend in a negative direction) New Measure is new; no comparison available

Improving health outcomes remains a long-term goal for CFC. In 2014, CFC participants' responses on self-reported health and the increased rating on the role of CFC services in maintaining and improving health suggested that CFC is experiencing some success in achieving this goal as does the consistently positive rating on the question about whether the case managers understand which services the individual needs to stay at home

Similar to prior years, about half of HCBS participants rated their health as "good" or better as compared to others of the same age. This compared to approximately 88% of Vermonters who again in 2013 reported that their health was "good" or "better" (Vermont Behavioral Risk Factor Surveillance System 2013 Data Summary, 2014).

Percent of participants ratings of "good" or better		2008	2009	2010	2011	2012	2013	2014
30. Self-reported health	HCBS	51%	49%	46%	51%	48%	49%	48%

Source: Thoroughbred Research Group

Although many participants do not rate their health highly in relation to other Vermonters, ratings of the CFC program's ability to help participants maintain or improve their health increased. This rating is consistent with last year's rating of 85%. For the second year in a row, more participants in Personal Care and Flexible Choices considered their services to be helpful in maintaining or improving health than participants in the Homemaker services and Adult Day Center programs.

Percent of participants ratings of "agree" or above:		2008	2009	2010	2011	2012	2013	2014
31. "My services help me to maintain or improve my health"	HCBS	New				85%	87%	93%

Source: Thoroughbred Research Group

Percent of participants ratings of "agree" or above 31. "My services help me to maintain or improve my health"	2013	2014
Personal Care	90%	95%
Flexible Choices	94%	92%
Homemaker services	83%	83%
Adult Day Center	83%	89%
Adult Family Care*	New	100%

*Program had a low response rate and results should be interpreted with caution.

Source: Thoroughbred Research Group

CFC participants' rating of their case manager's understanding of their service need remained relatively consistent and ratings for Personal Care and Flexible Choices were higher than those for homemaker and adult day center services. It may be that the impact of services such as personal care on health is clearer to participants than the contribution made by other CFC services.

Percent of participants ratings of "almost always" or above 32. "My case manager or support coordinator understands which services I need to stay in my current living situation"	2013	2014
Personal Care	93%	90%
Flexible Choices	100%	96%
Homemaker services	85%	83%
Adult Day Center	87%	89%
Adult Family Care*	New	100%

*Program had a low response rate and results should be interpreted with caution.

Source: Thoroughbred Research Group

Although participants do not rate their health highly in comparison to other Vermonters, most feel their services enhance their health. Overall, ratings on health outcomes are consistent with prior year ratings.

9. Service Array and Amounts

9. Service Array and Amounts: Array and amounts of services available in the community to people who are eligible for CFC increase.				
9.1 Does CFC further growth and development of home and community based services and resources throughout the state?		2014	Comparison to 2013	Comparison to 2006
33. Number of CFC participants by Nursing facilities, ERCs, PCA, Flexible Choices, Homemaker, Adult Day Health, 24 hour care, paid spouses	Nursing facilities**	1,847	+	+
	ERCs	444	+	+
	PCA	1,346	+	+
	Flexible Choices	266	+	+
	24 hour care	29	+	+
	Paid Spouses	37	+	+
	Adult Day (Highest and High Needs)	189	+	+
	Adult Day (Moderate Needs Group)	121	—	+
34. Number of providers of Nursing facility services, ERCs, PCA, Homemaker, AAA and Adult Day	Nursing facilities	40	40	—
	ERCs	XX	=	+
	HHAs (PCA and Homemaker)	12	=	=
	AAA	5	=	=
	Adult Day	14	=	Data unavailable

Sources: DAIL/DDAS SAMS Database and Vermont Department of Disabilities, Aging and Independent Living. All Providers. Retrieved from <http://dail.vermont.gov/dail-programs/dail-programs-providers>

= 2014 results not different (0-3% difference) + 2014 results better (trend in a positive direction)
 - 2014 results worse (trend in a negative direction) ** Reverse coded = a lower number is a better result

This outcome describes the effect of CFC on the array and amounts of long-term services and supports. In every setting other than nursing facilities, the number of individuals being served increased since 2006. Percent increases over the eight years ranged from 16% (PCA) to 2,140% (for Flexible Choices), reflecting the positive gains related to increasing the number of participants served in home and community-based settings.

33. Number of CFC participants	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nursing facilities	2,349	2,268	2,259	2,244	2,143	2,103	1,996	1,862	1,847
ERCs	261	342	328	349	354	389	385	411	444
PCA	1,112	1,352	1,312	1,268	1,248	1,214	1,214	1,290	1,346
Flexible Choices	5	28	70	85	89	99	106	112	266
24 hour care	2	11	11	10	9	10	7	9	29
Paid Spouses	0	0	3	3	4	10	10	37	37
Adult Day (Highest and High Needs)	198	216	223	209	215	203	192	235	189
Adult Day (Moderate Needs)	101	110	144	138	90	102	142	121	121
Homemaker	364	747	953	1,023	819	785	869	925	1,074

Source: DAIL

33. Number of CFC participants	Year 0	% Change Years 1 – 9 (2006-2013)
Nursing facilities		-21%
ERCs		70%
PCA		21%
Flexible Choices		5220%
24 hour care		1350%
Paid Spouses		3700%
Adult Day (Highest and High Needs)		-5%
Adult Day (Moderate Needs)		20%
Homemaker		195%

Source: DAIL

Since 2006, there was a slight decrease in numbers of nursing facilities. However, since last year, the number of providers has remained relatively unchanged. It is noteworthy that, in September 2013, CFC launched a new setting for HCBS, Adult Family Care, which will provide one more setting in the array of services available to CFC participants.

34. Number of Providers	2006	2007	2008	2009	2010	2011	2012	2013	2014
Nursing facilities	43	N/A	N/A	N/A	N/A	N/A	41	40	36
ERCs	61	N/A	N/A	N/A	N/A	N/A	61	61	
HHA (PCA and Homemaker)	12	N/A	N/A	N/A	N/A	N/A	12	12	11
AAA	N/A	N/A	N/A	N/A	N/A	N/A	5	5	5
Adult Day Center	14	N/A	N/A	N/A	N/A	N/A	14	14	

Source: PHI, 2006 Report and DAIL

CFC increased in its ability to serve participants in the community as seen in the increasing numbers of participants served by providers in home and community-based settings including Personal Care, Flexible Choices, 24 hour Care, Paid Spouses and Homemaker. In addition, even though the number of providers serving CFC participants has decreased, an examination of the DAIL website shows that there are now at least two home health agencies available to CFC participants in each county. This change is a positive development as it increases CFC participant's choice of provider.

IV. Conclusions and Recommendations

In the ninth year of the Choices for Care program, DAIL continues to achieve its mission to make Vermont the best state in which to grow old or to live with a disability with dignity, respect and independence. CFC enrollment increased with a larger percentage of individuals receiving services in a HCBS setting. Overall data indicate that CFC improved or maintained positive gains in many domains.

As Choices for Care is folded into the Global Commitment waiver, DAIL has an opportunity to align its quality improvement efforts with the "Triple Aim" by improving the experience of care, improving the health of populations, and reducing costs (Berwick, Nolan and Whittington, 2008)..

Information Dissemination

As mentioned earlier, Information and Dissemination is an integral component of the CFC program because individuals need accurate and complete information to make informed decisions about services and settings. It is therefore important that DAIL continues its support of the efforts of the Aging and Disability Resource Connection to increase awareness of the continuum of long-term support services and supports while ensuring that awareness of HCBS residential settings is also included. The My Innerview survey showed that doctors/hospitals were identified by four percent of individuals who elected an Enhanced Residential Care setting whereas sixteen percent of participants cited doctors/hospital as a reason for selecting nursing facilities. This substantial difference may be because doctors/hospitals are not aware of all of the HCBS options including residential settings. As suggested in the most recent policy brief on factors which can influence the return of transitioned CFC participants to a nursing facility, this lack of awareness of community alternatives among health care providers was a potential factor facilitating readmission to a nursing facility. Vermont has made strides in addressing this issue with initiatives such as the implementation of the Universal Transfer Protocol as a pilot project, but additional steps may be necessary as well. Discharge planners are an essential component of the medical team and a critical link between hospitals and the community. For this reason, they should be included in any targeted outreach efforts. DAIL and the ADRCs can build on the relationships that exist in those hospitals where representatives from the AAA and the HHA already participate in the daily discharge team meetings to pilot a training and peer-to-peer support program. The ADRC with the support of DAIL should reach out to discharge planners to determine their knowledge and awareness of long-term support services in the community for elders and people with disabilities; use this information to develop an in-person training; and explore the opportunities for establishing a peer-to-peer support system wherein discharge planners can reach out to a designated ADRC partner when questions arise.

In addition to doctors, nurses and hospitals, caregivers are also often not always aware of the full spectrum of residential settings available. (Long-Bellil, Henry, and Cumings, 2015). Working with the ADRC and case managers to improve marketing and outreach to caregivers is also an important strategy to ensuring that CFC participants and caregivers are fully aware of the available options. .

Access

Data shows that since 2011, the number of individuals waiting more than 60 days for financial eligibility determination for CFC has increased. This time frame meets federal standards, which have been relaxed over the last few years, but is not consistent with DAIL's goals for the program. Given the barriers that exist to gathering this documentation at a time when applicants may be least able to assist in that process, shortening these time frames is a daunting task, but one which may be worth taking on because of the potentially positive impact that reduced time frames might have on applicants. Working with the Department of Children and Families (DCF), DAIL may want to consider implementing a six-month performance improvement initiative to identify and to track the reasons for the delay in completing financial eligibility determinations. A simple-to-use form or template with the currently identified reasons can be supplied to the eligibility determination staff for this purpose. The information gained from this process will provide DAIL and the DCF with actionable data which can be used to identify next steps. DAIL may also find it useful to work with the ADRC to explore private and public grant funding options which can support a pilot to include additional staff, such as the Health Navigators or similar personnel, in the process of assisting applicants in collecting and submitting their financial

paperwork. Although case managers could also play a role, expanding the scope of their duties might undermine their ability to perform other critical tasks and reduce the quality of ongoing services to CFC participants.

The identification of services that participants state they want, but cannot get raises the question of whether their needs could be better assessed and met with a revised assessment process that incorporates input from an interdisciplinary care team. As noted in the most recent policy brief, a more comprehensive evaluation with input from practitioners representing various disciplines, accompanied by a more comprehensive care plan, has the potential to create a better fit between the individual's needs and the care they receive. Organizations such as the Commonwealth Care Alliance in Massachusetts and similar programs across the country can serve as models for such a revised approach.

Experience with care

According to this year's HCBS Consumer survey, the percentage of individuals identifying problems within specific CFC programs decreased. However, the percentage of those problems which were successfully resolved also decreased. DAIL may find it useful to address this issue by requiring providers to document complaints and their resolution. This information could then be reported to DAIL at regular intervals, during DAIL quality reviews, or be made available to DAIL upon request. Another alternative could be to require that they be reported to the Ombudsman.

Although all CFC participants receive materials about the Ombudsman's office at the time of enrollment, additional outreach may be necessary to increase their awareness of the Ombudsman's office as a resource. DAIL can work with the Ombudsman's office and perhaps with the ADRC to ensure that all CFC participants are informed that they can contact the Ombudsman's office if they have a problem. DAIL may find it useful to work with the Ombudsman's office to identify potentially effective means of informing the public about their role. Options may include posting information on DAIL and the Ombudsman's websites, distributing posters and other material informing participants about the role of the Ombudsman's office to health care providers and organizations frequented by elders, such as senior centers and adult day programs. In addition, DAIL may want to consider more targeted outreach via mail or telephone. Outreach directly to CFC participants may be particularly important for individuals who direct their own care and therefore do not have an agency to turn to when problems arise.

Throughout the life of the CFC program, DAIL and its providers have been committed to having a direct service workforce which is reliable, courteous and competent. Despite the best efforts of all involved, there continue to be problems with staff training and professionalism. The Evaluation Team encourages DAIL to work with providers to implement solutions to staffing problems, including the adequacy, management and training of staff. Online training for workers may be one approach to addressing this issue. DAIL may find it useful to build upon current efforts by home health agencies and unions to enhance staff training. In addition, the opportunity exists for DAIL and the union to work together along with CFC participants and caregivers to ensure that direct service workers across the continuum of care to devise additional training strategies. A strategy which can facilitate the provision of competency trainings may be similar to that used by Massachusetts where state policymakers worked closely with LTS participants, providers, consumers, caregivers, and the union to develop online evidence-based trainings that focus on the specifics of providing personal care and the broader perspectives on the philosophy of consumer control and the Personal Care Attendant program. For this latter aspect of the trainings, LTS participants can choose whether to provide the training (materials are available) or the worker can complete the training online. DAIL may find it useful to engage a contractor to facilitate a similar process. Yet another training initiative worth examining can be found in the state of Maine, which includes both in-person and online components. Such training may be one concrete step that DAIL could take to address the need for a more skilled direct care workforce

Lastly, although Flexible Choices participants rated certain aspects of the program highly, their rating of the amount of choice and control (82%) and the extent to which services meet their daily needs (86%) were lower than one might expect from a self-directed program. In the 2010 Self-Determination Policy Brief, DAIL gained information on the functioning of different aspects of the Flexible Choices program. DAIL may again find it worthwhile to explore Flexible Choices program participants' experiences with Choices for Care in a future policy brief.

Effectiveness

The principles and practice of person-centered planning have long been part of the Choices for Care program. DAIL is contemplating revising the standards for case managers, and should this initiative progress, this may be an advantageous time for DAIL to use an outside contractor to engage case managers. The outside contractor can facilitate an open discussion recognizing the intersection and impact of case manager's expressions of person-centered principles/theories and every day practice. In their qualitative study of case managers, Clemens, Wetle, Feltes, Crabtree and Dubitzky (1994) observed that this process brings to the surface congruencies and contradictions which may influence the full implementation of person-centered practice. For DAIL, the end product may help to respond to concerns about conflict free case management system by creating an agreed upon and clearly articulated practice regime for case managers irrespective of the agency with which they work. A similar process could be used to explore the experiences of consumers and caregivers with respect to person-centered planning.

The suggestion made above and in the most recent policy brief about revising the independent living assessment and care planning processes are also important steps toward creating a more person-centered system. This recommendation also included the incorporation of an interdisciplinary team approach, which would have the added benefit of enhancing the CFC program's ability to provide conflict-free case management by creating greater separation between those authorizing services and those delivering services in conformance with recent changes in HCBS regulations. Therefore, DAIL should contract with an outside entity to lead the effort to revise the ILA tool and the care planning tool.

As part of this effort to further realize its person-centered system, DAIL should involve CFC participants and their caregivers in ongoing monitoring of the program, either through the Advisory Board or other standing committees, or through more individual outreach. DAIL needs to ensure that in addition to case managers there are other sources which can inform participants and their caregivers of their role in the person-centered process. DAIL can also involve participants and caregivers in articulating their role in the person-centered planning process and to identify avenues for communicating that information with subsequent CFC participants, caregivers and professionals.

Quality of Life

As the use of CFC services ultimately impacts the quality of life of participants, it is important that DAIL establish work group to explore specific factors. One area to begin may be the concern raised by participants in the Consumer Survey that they are not "prepared in case of an emergency." Although DAIL has devised an Emergency Preparedness Planning Guide, this information may not be reaching a critical mass of CFC participants. Working with the partners of the ADRC, DAIL can ensure that CFC participants are aware of resources such as this one and the steps they can take to prepare for an emergency. DAIL may also find it useful to ensure that case managers are aware that they should address this issue by emphasizing its importance as part of the process of care planning or through some other mechanism.

Additionally, DAIL may want to consider collaborating with other entities to explore opportunities for improving CFC participants' satisfaction with their social lives and with the way they spend their time. One potential barrier to satisfaction on these measures is transportation. It is possible that innovative approaches to transportation involving ridesharing and volunteer drivers such as the approach utilized by ITNGreaterBoston, and even taxis in some areas could be an important step toward addressing this barrier. Another approach that has been shown effective has involved interventions that utilize a group format to promote greater social interaction (Dickens, Richards, Greaves, and Campbell, 2011). Lastly, online interventions such as the "Virtual Senior Center" that enables CFC participants to avail themselves of a variety of online classes and activities may be a useful component of a strategy to reduce isolation (Selfhelp Community Services, 2015). A revised assessment and care planning process should include a greater emphasis on social life and activities and the transportation services necessary to enhance access to these important aspects of life in the community.

Waiting Lists

As noted previously, the waiting list for the High Needs program ended in 2011. However, there continues to be a substantial waiting list for the Moderate Needs Group program. The state allots funds to the agencies, which are then responsible for providing services to eligible individuals. Each agency is responsible for managing its own waiting list. The number of people on those waiting lists varies substantially between agencies. Historically, some agencies have not been

able to use all of their allotted funding, despite having a waiting list of eligible individuals. Although the number of individuals potentially eligible for MNG services makes the elimination of a waiting list unlikely, DAIL may find it useful to form a workgroup to examine how waiting lists are managed and formulate mechanisms for reducing them to the extent possible.

Service Array and Amounts

In the 2012 policy brief, we recommended that Vermont adopt a two-year pilot to permit non-medical providers to offer services to CFC participants. Full adoption of this approach has the potential to expand CFC participants' choice of provider and could be an important step forward in promoting choice and ensuring that their needs are met.

Evaluation

In 2012, the evaluation plan was revised to encompass an assessment of services across the continuum of care. It was recognized that in order to do an accurate assessment of participant experiences across the continuum of care, the same question should be asked across all settings. Currently the survey instruments used by the contracted organizations conducting nursing facility, Enhanced Residential Care/Assisted Living and home and community-based services consumer satisfaction assessments have the flexibility to incorporate new questions. DAIL should convene a meeting with all of the contractors conducting surveys to identify those questions which will be similar for all surveys.

Conclusion

In its final year as a separate 1115 Research and Demonstration waiver, CFC continues to meet the needs of its participants. This year's evaluation identified a few new issues and a few recurring issues that DAIL should continue to address as the CFC program is incorporated into the Global commitment to Health waiver. With its tradition of innovation, Choices for Care is well positioned to meet the future needs of CFC participants.

Resources

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