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Vermont Choices for Care: Evaluation of Years 1-5

Final Report

Prepared by

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Table of Contents

Highlights of CFC Evaluation Years 1-5	2
I. Introduction.....	4
II. Evaluation Framework	4
III. Evaluation Results and Discussion.....	7
CFC’s Fifth Year Developments	7
Profile of CFC Enrollment.....	7
A. Information Dissemination.....	9
B. Access	11
C. Service Effectiveness	13
D. Experiences with Care.....	17
E. Quality of Life Outcomes.....	18
F. Applicant Lists.....	20
G. Budget Neutrality	22
H. Public Awareness of Long-Term Care	23
I. Health Outcomes.....	24
IV. Conclusions and Recommendations	24
References	27

Acknowledgement and Note: This evaluation report builds off of and expands the evaluation reports written by former members of the UMMS evaluation team, mostly notably, the 2009 Years 1-4 Evaluation report by Emma Quach and David Centerbar. Where appropriate, this report presents tables of data from previous years and then reports on the same indicators for year five. Similarly, language from previous reports was used, as appropriate, for the same effect. For example, information on the evaluation framework and data sources was the same for this year as in past years; therefore, the same language was used to a large extent. Please see references for specific reports.

Highlights of CFC Evaluation Years 1-5

In October 2005, Vermont launched the Choices for Care (CFC) 1115 Medicaid waiver targeting adults (including older adults) with unmet long-term care needs. The waiver was designed to further shift the state's long-term care utilization and spending to community care. Several key design features were put in place to achieve this goal. First, the waiver brought under its oversight the entire continuum of long-term care services (home and community-based services or HCBS, enhanced residential care or ERC, nursing homes) as well as HCBS delivery types (self-directed care, surrogate-directed care, Cash and Counseling-based Flexible Choices, PACE, and traditional agency services). While CFC sought to increase access to community options for participants, the waiver was also designed to give priority to individuals at the highest level of need. Specifically, applicants meeting CFC highest needs had a choice of any long-term care setting without being put on a waiting list for enrollment. While applicants meeting high needs could qualify for the same amount and types of services as highest needs, they might experience delays in enrollment if funding availability were in question, i.e., if a high needs applicant list was active. Similarly, moderate needs participants, who may be below nursing home level of need and/or may not meet financial criteria for Medicaid long-term care, could still receive limited homemaker, adult day, and case management from CFC services, but could also be put on an applicant (waiting) list for services.

The fifth year of CFC (2010, data reported through October 2010) was marked by economic challenges to Vermont as well as the country as a whole. During this year, state fiscal challenges led to a reduction of DAIL workforce, reduction in CFC services and reductions in provider rates. Despite these challenges, DAIL developed new initiatives and continued to work on issues that have been identified in prior years such as:

- Implementation of an application process which includes clinical and financial eligibility in one form.
- Expansion of service options through the Flexible Choices program.
- Increase use of PACE.
- Assessment of hospital discharge planning processes to identify areas for increasing awareness of long-term support services.
- Progressing towards a larger percentage of dollars spent in the community than in institutional settings; in eight counties, over 50% of people receive support through home and community-based services.

Analyses of the fifth year of enrollment and HCBS participant survey data point to some consistent progress towards desired outcomes—particularly for HCBS participants. Due to changes in the consumer satisfaction survey methodology, the overall ratings in many instances are slightly less than in previous years. For 2010, the consumer satisfaction survey encompassed data from the Attendant services program, the High Technology Home Care program, the Traumatic Brain Injury program and the CFC services. Service-specific data showed variation in ratings. Recognizing that the ratings were generally high in the 80% - 90%, the consumer satisfaction survey clearly shows that long-term support service consumers' satisfaction with the services they receive was high. In keeping with previous evaluations, we present the overall ratings in this section:

- *Information Dissemination:* HCBS participants consistently reported having "choice and control in planning for services", with 81% reporting "good" or "excellent" to this survey question in 2010.

- *Access:* In 2010, 84% of HCBS participants consistently reported that the “timeliness of services” was “good” or “excellent”.
- *Effectiveness:* 88% of HCBS participants reported that “services met their needs” in 2010. Enrollment data also pointed to the ongoing trend of highest needs participants being increasingly served in HCBS and ERC. Furthermore, the proportion of all highest and high needs participants supported in the community with HCBS, as opposed to nursing facilities, is 48%.
- *Experiences of Care:* Virtually all (96%) HCBS participants reported “good” or “excellent” when asked about the “courtesy of others”.
- *High Needs Applicant List:* Although the high needs applicant list has been active most of the five years, in 2007, the number on the list fell to zero. The list was reinstated in 2008 and the number of individuals on the list in October 2010 was 30.
- *Budget Neutrality:* DAIL continued to manage CFC spending in a way that stays within annual appropriations, thus ensuring budget neutrality for the demonstration period.

For HCBS participants, a few issues stand out as ones where there is room for even more progress. The data continued to show that participants rating of their quality of life and health outcomes remain lower than the general public. The HCBS participants and the general Vermont population are different on various dimensions (e.g., age, chronic conditions/co-morbidities, and functional impairment) that are likely to contribute to the gap in self-reported health between the two groups. DAIL may want to investigate whether the design of CFC is truly able to affect these outcomes and if so, whether they wish to devote additional resources toward their improvement.

Another aspect of the program, though small, has the potential to have a significant impact: the percentage of participants who said that when they had a problem, it was resolved. For the overall response, 86% of individuals rated their satisfaction with the resolution of a problem or concern as Excellent or Good. However, the rate of resolution differed by specific program. Although not very high in any program, it is important that in maintaining its quality of services, all staff interacting with CFC consumers know that a response must be made to all consumer problems and concerns.

In closing, process and outcome evaluation data over the five years show some very promising results, such as the increase of HCBS setting vis-à-vis institutional settings in serving highest needs participants and the consistently high satisfaction rates of HCBS participants with multiple aspects of CFC services. An important note is that CFC and its priorities may be impacted by larger-scale changes in terms of health care reform, such as the movement toward a single payer and initiatives related to dually eligible (Medicaid and Medicare) individuals. As these changes are discussed and implemented, CFC will need to determine if and how its program and its logic model need to shift.

In addition, in the coming years, particularly if the challenging fiscal climate persists, DAIL will need to prioritize limited resources. Like other states facing revenue shortfall, Vermont may need to determine how much it can invest in broader goals such as improving participants’ general health and quality of life compared with investments in meeting basic needs, and to balance its commitment to quality with its desire to serve all eligible participants.

I. Introduction

In October 2005, Vermont implemented Choices for Care, an 1115 Waiver Demonstration program. The purpose of the program was to ensure that older adults and people with disabilities have access to long-term support services in a setting of their choice.

To achieve this goal, the Waiver encompassed the entire continuum of long-term support services including Home and community-based services (HCBS), Enhanced Residential Care (ERC), Nursing facilities, self-directed care, surrogate-directed care, cash and counseling-Flexible Choices, PACE and traditional agency services. To fully support the provision of community services, a three-tiered system was established in which individuals with long-term care needs were identified as: highest needs, high needs and moderate needs.

Individuals identified as highest needs can select the setting which best meet their needs and 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 an applicant (waiting) list. Those individuals identified as moderate needs are below the level of nursing facility placement, may not meet the financial criteria for Medicaid long-term support services and can receive limited home-maker services, adult day services and case management. Similar to the high needs group, moderate needs individuals may also be placed on a waiting (applicant) list.

This fifth year of the 1115 Demonstration Waiver has been one of transition. Similar to most states across the country, Vermont had to contend with the on-going economic challenges, while ensuring that the Choices for Care program continued to meet the long-term care needs of older adults and people with disabilities. The budget readjustment which was requested of all state departments, contributed to DAIL's decrease in rate payment to Home-health agencies. However, the CFC program maintained services and DAIL with the support of stakeholders determined that the state would apply for an extension of the Waiver. The next years appear to continue the time of transition as health care reform and initiatives related to dually eligible individuals are put forth. CFC will need to take care to ensure that it analyzes these changes and determines if and how it (and the logic model upon which it and the evaluation is based) are impacted.

To meet federal waiver requirements and assess their own progress, DAIL contracted with the University of Massachusetts Medical School (UMMS) in 2007 to serve as an independent evaluator. Each year since 2007, UMMS has produced an evaluation report that summarized major changes in CFC policies or procedures as well as initiatives or efforts CFC has undertaken, the impacts on participants and the long-term care system CFC has had thus far, and policy areas for Vermont policy-makers to focus on in the coming years. Like previous annual evaluation reports, the current report builds upon past evaluation data while focusing on the most recent year's (2010, through October 2010) evaluation results.

II. Evaluation Framework

To guide all evaluations and policy analyses related to CFC, UMMS and DAIL developed a comprehensive evaluation plan. The evaluation plan was further refined through input from Vermont stakeholders and national long-term care experts at a roundtable discussion co-hosted by DAIL and

UMMS in January 2008. The desired outcomes for CFC are as follows, with the short-term desired outcomes expected to be achieved during the demonstration period and the long-term desired outcomes expected to be achieved after this period. These outcomes provide the framework for process and outcome evaluations of CFC. The evaluation is also shaped by the short and long term outcomes and corresponding questions identified in the Waiver application.

Short-term Desired Outcomes (1-5 years):

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:
 - To what extent did participants receive information to make choices and express preferences regarding services and settings?
2. **Access** - Choices for Care participants have timely access to long-term care supports in the setting of their choice:
 - Are new Choices for Care participants or nursing home residents who seek discharge able to receive Choices for Care services in a timely manner?
 - To what extent are Choices for Care participants receiving the types and amounts of supports consistent with their currently assessed needs?
3. **Effectiveness** - Participants receive effective home and community-based services to enable participants to live longer in the community:
 - Is Choices for Care increasing in its ability to serve participants in all Choices for Care levels of need in the community?
 - To what extent are participants' long-term care supports coordinated with each other for the purpose of providing effective care?
 - To what extent did Medicaid nursing facility residents' acuity, as measured by physical and cognitive performance, change over the Demonstration period?
4. **Experience with Care** - Participants have positive experiences with the types, scope and amount of Choices for Care services:
 - To what extent do Choices for Care participants report having positive experiences with the types, amount, and scope of Choices for Care services?
5. **Quality of Life** - Participants' report that their quality of life improves:
 - To what extent did Choices for Care participants' reported quality of life improve over the Demonstration period?
6. **Impact of Waiting List** - Choices for Care applicants who meet the high needs criteria will have equal access to services regardless of the setting of their choice (e.g., nursing home, enhanced residential care, home care):
 - 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 Choices for Care participants is equal to or less than Medicaid and home and community-based services funding:
 - Were the average annual costs of serving Choices for Care participants less than or equal to the projected annual costs for serving this population in the absence of the waiver?

Long-Term Desired Outcomes (over 5 years):

1. **Public Awareness** - Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and individuals have enough information to make decisions regarding long-term care:

- To what extent are Vermont residents who are hospitalized aware of long term care setting options at the time of discharge?
- To what extent are Vermont residents who are hospitalized supported in making decisions regarding how their long-term care needs are met at the time of discharge?

2. **Health Outcomes** - Choices for Care participants' medical needs are addressed to reduce preventable hospitalizations and long-term care needs are effectively addressed:

- To what extent are Choices for Care participants' long-term care needs being effectively addressed?
- To what extent are participants' medical needs addressed to reduce preventable hospitalizations?

This evaluation report will provide evidence related to each outcome. However, in some cases, data are not available to address specific questions. In those cases, data were analyzed and are presented to describe progress made for that outcome, but not for a certain question. For example, in Effectiveness, data were not available to analysis acuity; however, data on the number of nursing facility beds were presented.

Data Sources and Analyses

In order to evaluate the CFC program, information was reviewed from previous policy briefs, minutes of the Advisory Group, DAIL's annual budget reports, Semi-annual reports to CMS, and monthly meetings with DAIL staff. From these sources, the Evaluators obtain information about the functioning of the program and stakeholders' perspectives.

To understand the implementation process of CFC and provide context for the evaluation, we analyzed Quarterly/Semi-Annual CFC Reports to CMS between October 2005 and October 2010 and DAIL Advisory Board Meeting Minutes between October 2005 and October 2010. We concentrated our reviews on information about year five implementation. Quarterly/semi-annual CFC reports to CMS documented the changing environment in which CFC operated during these five years. They also documented activities that took place, generally, those at the state level. DAIL Advisory Board meeting minutes covered the range of programs or topics that DAIL oversees, with CFC being one of these programs. The Advisory Board members include consumers, consumer advocacy groups, a trade association, and individual providers. The minutes captured at a very high level some discussions, feedback, and concerns related to CFC.

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

- CFC HCBS consumer feedback: Between 2006 and 2010, HCBS participant feedback was gathered by an independent survey contractor, either Macro International or Market Decisions, asking HCBS participants for their views on several aspects of CFC services, such as the choice and control in care planning, timeliness of service, and quality-related aspects of services. In addition, HCBS participants also described their general health and certain aspects of their quality of life. We reviewed survey data collected in November 2010, 2009, 2008, 2007, and 2006. There are differences between the 2010 survey and the 2009 survey. A significant difference is that the 2010 survey interviewed consumers of the long-term support service System including the Attendant Services, Traumatic Brain Injury and the High

Technology Home Care programs. Similar to the 2009 consumer survey, the 2010 survey provides data on specific CFC programs such as the Adult Day Centers, Personal Care Services, Flexible Choices and Homemaker Services.

- CFC enrollment and application data: Enrollment data collected by DAIL as part of the waiver administration track the number of CFC participants, the CFC setting in which they were served, their CFC level of need, as well as high needs applicant list and moderate needs waiting list. In addition, DAIL tracks the number of applications to CFC by major CFC settings (nursing facility, ERCs, HCBS, and moderate needs group). Applications provide an indirect means of assessing general knowledge and demand for different long term care settings.
- DAIL's calculations of CFC projected 5-year budget, annual appropriations, and actual spending: DAIL reports annual state appropriations and actual CFC spending summary data.
- Hospital Discharge Planning Policy Brief: We conducted key informant interviews with stakeholders in the hospital discharge planning process to explore how hospital discharge planning currently influence Vermont consumer choice and use of long-term care settings.

Table 1 displays the primary data sources on which our assessment of each desired outcome is based.

Table 1: Data Sources for Each Desired Outcome.

	Data Sources for Process & Outcomes Evaluation		
<i>Information Dissemination</i>	HCBS Consumer Feedback	Reports to CMS	Policy Brief
<i>Access</i>	HCBS Consumer Feedback	Reports to CMS	Policy Brief
<i>Effectiveness</i>	HCBS Consumer Feedback	Reports to CMS	CFC Enrollment Data
<i>Quality of Life</i>	HCBS Consumer Feedback		
<i>Experiences with Care</i>	HCBS Consumer Feedback	Stakeholder Feedback	
<i>Impact of Waiting list</i>	CFC Enrollment Data	DAIL Advisory Board Minutes	
<i>Budget Neutrality</i>	DAIL Budget Reports	Reports to CMS	
<i>Health Outcomes</i>	HCBS Consumer Feedback		
<i>Public Awareness</i>	CFC Applications Data	Reports to CMS	Advisory Board Minutes

III. Evaluation Results and Discussion

CFC's Fifth Year Developments

The fifth year of CFC was marked by a challenging economic environment, not only for Vermont but for the entire country. During this time, DAIL experienced budget rescissions which led to cuts to some provider reimbursement rates in CFC as well as other programs. DAIL completed its application for the extension of the waiver. Working with the VT ADRC, DAIL commissioned an assessment of potential service users and members of immigrant communities.

Profile of CFC Enrollment

In year five, there was a slight decrease in the number of individuals enrolled in the CFC program. During five years of CFC implementation, total CFC enrollment steadily grew in the first three years, before leveling off and decreasing slightly in the last two years. Just as most of the increases were largely

attributed to expanded enrollment in the moderate needs group, the leveling off also appears due to the moderate needs group's decreases. These decreases (24% to 20%) seem to be a result of the ongoing use of a moderate needs applicant list.

Following the moderate needs group (which experienced the largest increase in enrollment over the five years), the high needs group had the second largest enrollment increase. The proportion of high needs enrollment of total CFC enrollment nearly doubled from year 1 to year 4 and remains steady at 11% of all enrollment. However, high needs enrollment, which exceeded moderate needs enrollment in year 1, fell behind moderate needs enrollment after the first year of CFC and, in year five, continued the trend from year four of constituting about slightly less than half of moderate needs enrollment.

The highest needs group numbers continued to hover around 3200 in real numbers, similar to years past. Because moderate needs enrollment and high needs enrollment grew, highest needs enrollment consistently fell as a proportion of total CFC enrollment. Although highest level of need participants still constituted the largest proportion of all CFC participants, in October 2010, CFC was serving over 30% in other need level groups. See Table 2.

Table 2: Point-in-Time Enrollment by Level of Need

	Moderate (%)	High (%)	Highest (%)	Total
11/05	2	7	91	3537
10/06	13	6	82	4004
10/07	20	12	68	4643
10/08	23	13	64	5014
7/09	24	11	65	4991
10/10	20	11	68	4774

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

In terms of enrollment by setting, given the historical institutional bias, nursing facilities have been and remain the setting that serves the biggest number of CFC participants. Data from October 2010, however, highlight the overall downward trend of nursing home enrollment. From 2005 to October 2010, nursing home CFC enrollment dropped from 66% to 52%. This trend was coupled with a trend toward higher use of HCBS and ERC settings, in which the percentage jumped from 34% to 49% over the same timeframe. See Table 3.

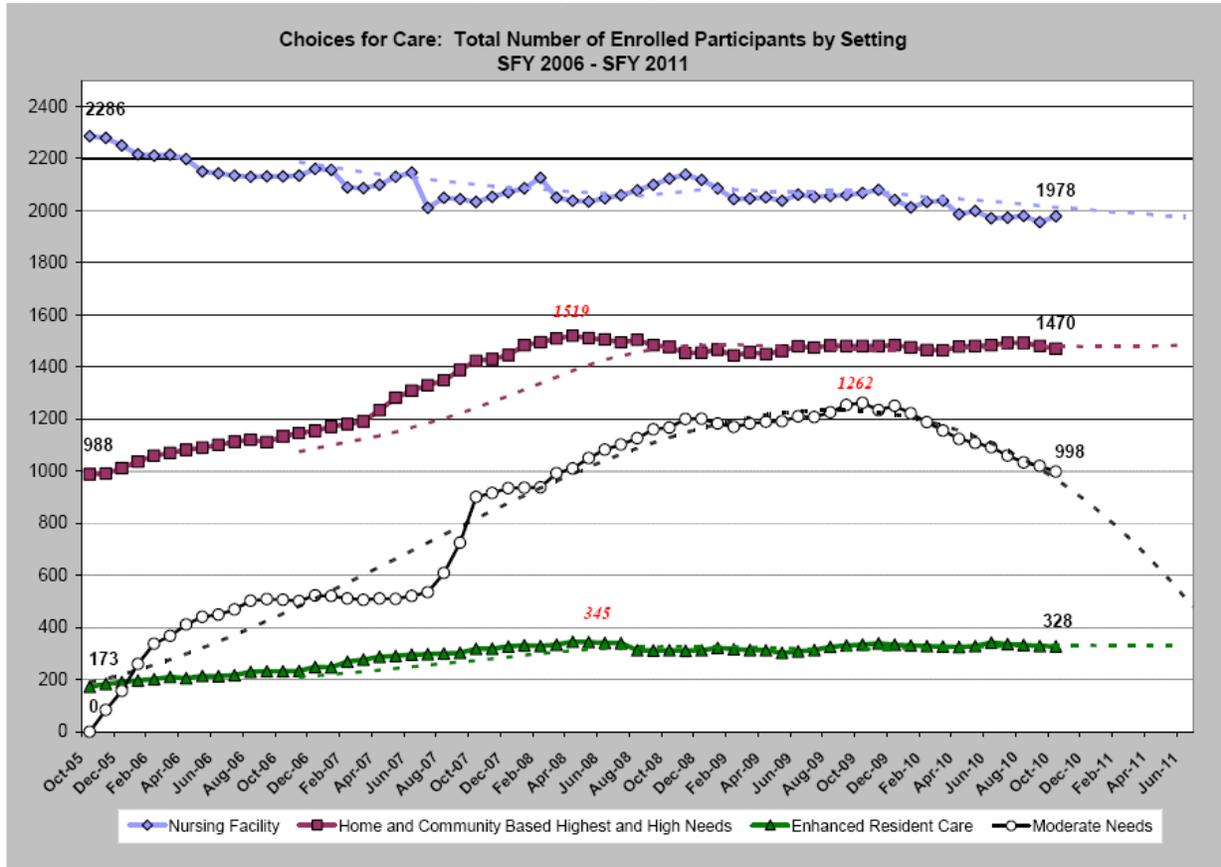
Table 3: Point-in-Time Enrollment of Highest/High Participants by Setting

	NF (%*)	HCBS (%*)	ERC (%*)	Total # High/Highest
11/05	66	29	5	3453
10/06	61	32	7	3497
10/07	53	38	9	3742
10/08	54	38	8	3847
7/09	53	39	8	3783
10/10	52	40	9	3776

*Percent of total High and Highest Needs Groups in that month/year.
 Source: DAIL
 Numbers may not add up to 100 due to rounding.

Enrollment in HCBS and ERCs rose sharply in the first four years, with increases in ERC from 173 in October 2005 to 335 in October 2009 and increases in HCBS from 998 in 2005 to 1480 (50% change) four years later. Enrollment numbers for both settings in October 2010 remained relatively steady (with minute decreases of 2% or less) with 328 in ERC and 1470 in HCBS. As the Renewal Application for the CFC Waiver noted, “Although nursing facilities continue to be the most frequent setting for participants, Vermont has significantly increased the number of Vermonters receiving community-based services since implementing Choices for Care, while reducing the number of individuals receiving services in nursing homes.” See Figure 1.

Figure 1. Total Number of Enrolled Participants by Setting



Source: DAIL

A. Information Dissemination

In the first four years of implement, DAIL disseminated information to both providers (years one through three) and consumers (a focus in year four). For example, DAIL developed the CFC Participant Handbook. Specifically, the Handbook listed specific services under each setting (HCBS, ERC, NF) and service delivery options available under HCBS (Consumer-Directed, Surrogate-Directed, Agency Services, Flexible Choices, and PACE). The Handbook represented a step forward in standardizing information dissemination and assuring that all participants receive the same core information of available services under CFC.

Additionally, DAIL updated the CFC application to include the clinical and financial eligibility forms in one document. Although this revision was aimed at increasing consumer awareness and streamlining the

application process, some stakeholders have questioned the change. During interviews for the policy brief on hospital discharge, respondents remarked that the current CFC application is time-consuming and overwhelming to families and clients. Respondents noted that the extent of financial data required is often times daunting to the applicant and to the family members.

Although everyone participating in the discharge policy brief understood that DAIL wanted to streamline the financial assessment process, they nonetheless also commented that they found it more difficult to track the status of an application with the newly implemented application process. Previously, they contacted the local LTCCC and often received a prompt response to their inquiry on the status of an application. Today, many respondents observed, “You leave a message and you are not sure when someone will get back to you.”

Currently, DAIL’s website is one source of information about the CFC program. There are other sources of information as well. In the current Market Decisions survey, when consumers were asked how they first learned about long-term services, 22% responded friends. Hospitals at 12% and health care providers with 10% were the other two common sources for information.

Information dissemination not only reflects CFC’s desire to provide consistent and critical information about CFC to potential clients, it also reflects CFC’s interest in empowering clients in the making of choices that affect their care. In this respect, survey responses from HCBS participants over the past five years indicated that the vast majority of respondents (at least 81% in 2010) rated positively the “choice and control” they had in planning for their services and 91% rated positively that people “listened to needs and preferences”. These results greatly supported the work of both CFC case managers and caregivers. See Table 4.

For Table 4 and all overall data tables related to the survey, it is important to note that the overall “All HCBS Consumer feedback” in year 5 includes CFC participants as well as consumers of Attendant services, High Technology Home Care services and Traumatic Brain Injury services. This represents a slightly larger and different population than in previous years, so comparisons are less direct. However, we include these overall data to provide some historical continuity in the evaluation in this year of transitioning survey contractors. In an effort to provide the most accurate description possible, we are also including CFC-specific data. In future years, we anticipate concentrating more on these specific data.

Table 4: HCBS Consumer Survey Indicators related to Information Dissemination

All HCBS Consumer Feedback	Year 1	Year 2	Year 3	Year 4	Year 5
Percent of participants ratings of “good” or “excellent” to survey items:					
<i>“Choice and control when planning for their services”</i>	86%	91%	89%	90%	81%
<i>“People listen to [their] needs and preferences”</i>	86%	90%	90%	94%	91%

Source: Market Decisions

Although the overall percentage for “Choice and Control” reflects a slight decrease, we found that in 2010, CFC HCBS participants in the majority of particular programs reported satisfaction on “choice and control in service planning” at a higher rate than the overall rate indicated. Tables 5 and 6 provide program-specific information on the percent of consumers who rated as either “good” or “excellent” choice and control and “listened to needs and preferences”.

Table 5: “Choice and Control in planning their services” by Program 2010

Program	Percent
Personal Care	84%
Flexible Choices	88%
Homemaker services	76%
Adult Day Center	81%

Source: Market Decisions

Table 6: “People listen to needs and preferences” by Program 2010

Program	Percent
Personal Care	95%
Flexible Choices	85%
Homemaker Services	87%
Adult Day Center	90%

Source: Market Decisions

B. Access

In addition to providing more choices to participants, CFC seeks to provide services in a timely manner. Based on the 2010 survey, 84% of consumers stated that their services were timely. While this represents a slight decrease, certain programs were rated more highly in terms of timeliness. See Tables 7 and 8.

Table 7: HCBS Consumer Survey Indicators related to Access

HCBS Participant Feedback	Year 1	Year 2	Year 3	Year 4	Year 5
Percent of participants ratings of “good” or “excellent” to survey items					
<i>“Timeliness of services”</i>	84%	90%	89%	88%	84%
<i>“Services fit in their schedule”</i>	86%	90%	90%	92%	88%

Source: Market Decisions

Table 8: Timeliness by Program, 2010

Program	Percent
Personal Care	86%
Flexible Choices	92%
Homemaker Services	84%
Adult Day Center	87%

Source: Market Decisions

In 2009, 97% of self-directing participants reported satisfaction that “services fit schedule” (Table 7) whereas in 2010 the question changed a little to ask consumers “How would you rate your satisfaction with when you received care?” 88% of consumers rated their satisfaction as Excellent or Good. The extent to which consumers rate their satisfaction as Excellent or Good is fully illustrated in the responses to the individual services. See Table 9.

Table 9: Schedule of care by Program, 2010

Program	Percent
Personal Care	91%
Flexible Choices	91%
Homemaker Services	84%
Adult Day Center	85%

Source: Market Decisions

Throughout the duration of the CFC program, DAIL has made advances both in the arena of service delivery and system change. The state’s commitment to expanding services within the community was further exemplified by its exploration and discussion of possible actions even as it faced a changing economic landscape. After its pilot of a small Adult Foster Care program, DAIL continues to review implementation options with various stakeholders. Additionally, during an Advisory Board meeting there was discussion of the steps needed for a nursing facility to convert to an Enhanced Residential Care setting. This suggests that there is on-going dialogue between DAIL, consumers and providers on options which will increase the state’s capacity to provide long-term support services in community settings.

In examining various routes of access to the CFC program, DAIL worked with the UMMS Evaluation Team to complete a hospital discharge policy brief. Even though there is an understanding that hospital discharge planning can rely on the use of many services (i.e., hospice, rehabilitation settings, nursing facilities, and HCBS), the brief focused, to the extent possible, on the impact of CFC as an aid in the discharge planning process to allow a client to regain and maintain his/her capacity to select a community setting.

The policy brief described how hospital discharge planning processes currently influence Vermont consumer choice and use of different long-term care settings. Literature and document reviews as well as telephone interviews with 28 key informants were conducted. These key informants included staff at Vermont hospitals, nursing facilities, home health agencies, area agencies on aging, CFC/DAIL/DDAS, Vermont Department of Licensing and Protection, and trade associations with interest in hospital discharge planning.

We found hospitals, community providers, and nursing facilities engaged in many best practices related to discharge planning in general. Discharge planning can be effective, allowing for choice through communication and education, or ineffective, derailing choice on the part of the consumer and family. There are several policy recommendations for the Department of Disabilities, Aging, and Independent Living (DAIL) to consider. These recommendations would enhance discharge planning processes through low-cost and no-cost strategies, designed to foster communication at all levels and in multiple settings. For example, we recommended that education for providers and the general public should include information about Vermont Choices for Care (CFC) as well as other services. Other recommendations included:

- Work with all interested parties to encourage hospitals to have discharge planning teams which are inclusive of the person being discharged and representative community and nursing facility providers.
- Encourage active and meaningful attendance at Waiver Team meetings for key discharge planners involved with complicated or long-term patients.
- Create online, web-based trainings about CFC that can be used by hospitals and community organizations to orient their staff to the CFC program and application process.
- Encourage and support an online database that allows hospitals, nursing facilities, and community service providers to indicate either patients ready for discharge or capacity to accept patients.

- Design public awareness campaigns and materials about home- and community-based services and the organizations that provide them which are aimed at current and future consumers.
- Develop online secure electronic health records to facilitate the exchange of information and the flow of the discharge planning process. Expand Vermont's electronic health record system to allow a hospital to determine whether a client is a CFC client and ensure that other relevant data related to hospitalizations and services are available to hospitals, community agencies and nursing facilities.
- Explore, with community partners, reimbursement options to allow community organizations (VNA, HHA, and AAA) to increase services through innovative service delivery alternatives.

Some of the recommendations above may need to be revisited or may be issues to consider as health care reform and initiatives related to the dually eligible population are discussed and implemented. The key informant interviews which informed the policy brief and the writing of the policy brief occurred in fall 2010/winter 2011 before many of these initiatives had been discussed and developed.

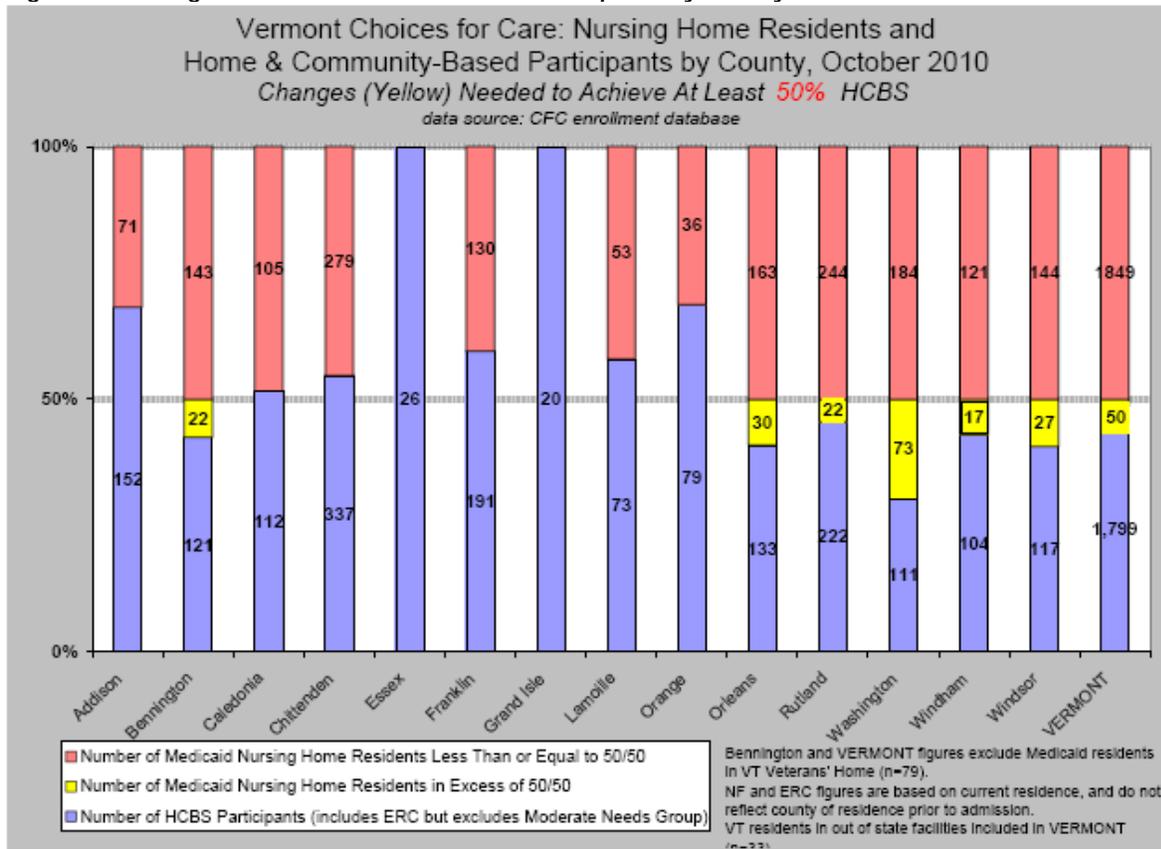
During this period, DAIL also took the opportunity to collect information on individuals who were not currently using the CFC program. A report was commissioned with the aim of gathering information for the implementation of the Vermont Aging and Disability Resource Center (ADRC). Because the ADRC is an integral part of the long-term support service system, the information gathered may also be useful to the functioning of the CFC program. The focus groups conducted by Fifth Elements Associates gathered information from individuals 70 years and older, older adults with acquired disabilities, caregivers and immigrants. The report provided a profile of individuals who may access services in the future, some of the barriers which are constraining their access and avenues to increase awareness and outreach to these potential consumers.

By embarking on the above project, DAIL enhanced a short term goal of determining the long-term support needs of individuals and access and gained information for a long-term goal of increasing public awareness of the CFC program. Together, the information gained from the focus groups, the hospital discharge policy brief and the feedback for the preparation of the Waiver application was instructive in identifying issues facing current and possible future consumers.

C. Service Effectiveness

Although the state has not reached a 50% split between nursing facility use and home and community-based services, a review of the data suggests that the state continues to progress towards this goal. In October 2010, eight counties had reached or surpassed the 50-50 goal, while the other counties were within 241 residents (combined) of that goal. See Figure 2.

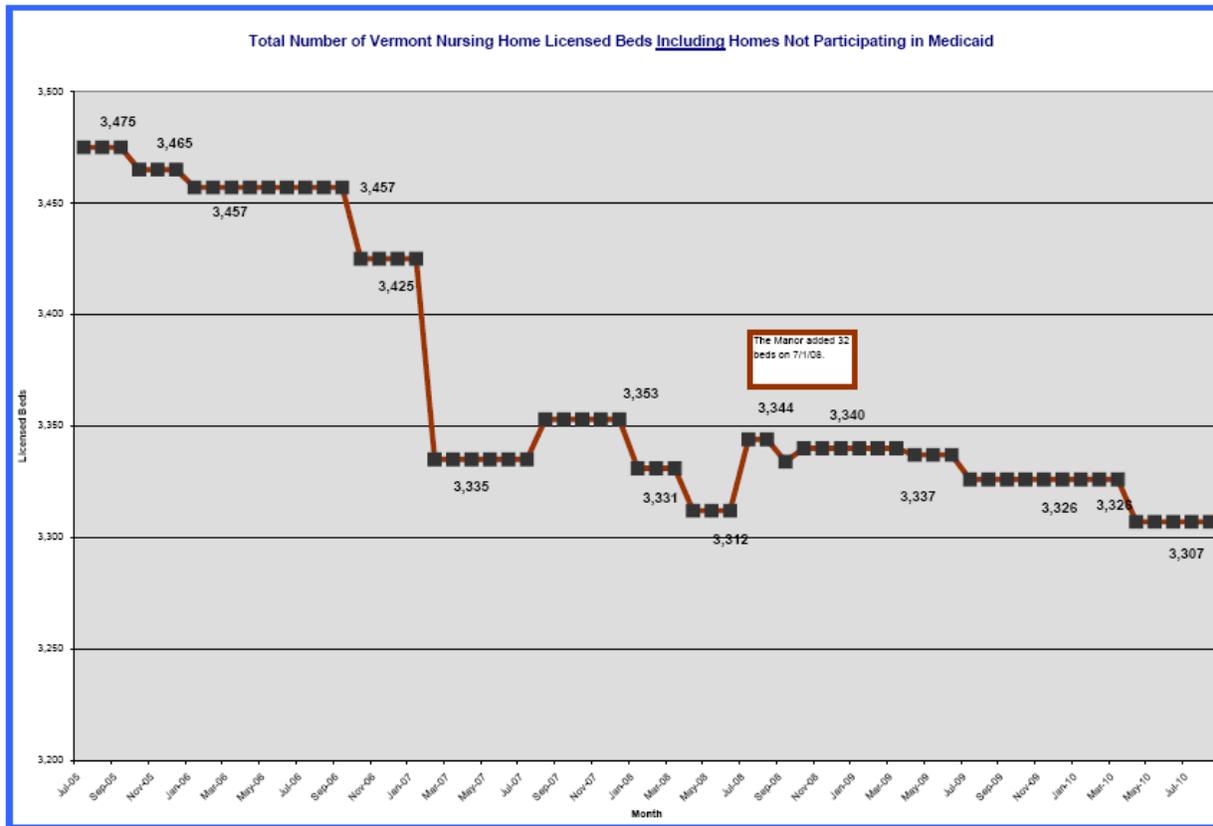
Figure 2. Nursing Home Residents and HCBS Participants by County, October 2010



Source: DAIL

A further sign of CFC effectiveness can be found in the on-going closure of nursing facility beds. In an April 2010 meeting of the Advisory Board, it was noted that a number of unoccupied nursing facility beds were closed. This trend is clearly reflected in the state's data. See Figure 3.

Figure 3. Licensed Nursing Home beds in Vermont



Source: DAIL

Another indication of the effectiveness of CFC services may be seen in the program’s applicant lists. Due to the current ongoing financial constraints, applicant lists for both high needs and moderate needs have been instituted. Even though, as of October 2010, both lists were active, there were not as many people on the high needs list (30) as there were on the waiting list prior to CFC (241). DAIL recognizes the existence of these lists as one indication of the demand for CFC services and strives to decrease the number of individuals on the lists.

CFC not only encompasses services in multiple settings (e.g., nursing homes, HCBS) but also, serves a participant population with diverse needs. Over the past four years, DAIL has initiated efforts to meet service needs of “niche” groups within the larger CFC population, whether these participants are receiving HCBS or services in other settings. For example, as noted in previous evaluations, DDAS signed a Memorandum of Agreement giving priority to CFC participants who were also DMH clients and a discharge planning protocol was established to facilitate transitions for individuals from the Vermont State Hospital and the correctional facility who would access CFC and non-CFC provider networks in the community.

DAIL seeks to ensure that existing service options are effective. Participants receiving HCBS have consistently indicated that their services “met their needs”. From 2006-2009, between 89% and 95% of HCBS participants rated services as “good” or “excellent” in terms of how they met their needs. In 2010, nearly 9 in 10 (88%) consumers rated the extent to which the services meet their daily needs as Excellent or Good. This trend is further exemplified in consumers’ responses to specific programs. See Tables 10 and 11.

Table 10: HCBS Consumer Survey Indicators related to Effectiveness

HCBS Participant Feedback	Year 1	Year 2	Year 3	Year 4	Year 5
Percent of participants ratings of "good" or "excellent" to survey item:					
"Services meet needs" is rated good or better	89%	91%	91%	95%	88%

Table 11: Meets needs by Program, 2010

Program	Percent
Personal Care	92%
Flexible Choices	90%
Homemaker Services	85%
Adult Day Center	83%

Source: Market Decisions

CFC has sought to enhance HCBS as an option serving persons at the highest level of need, an indicator of HCBS' effectiveness in the CFC evaluation plan. As noted, over the past five years, CFC has increased its enrollment substantially, with marked increases in HCBS. Currently, of all individuals at highest needs, the percentage of those participants being served either with HCBS or ERC is 43%, representing a continuation of the trends seen in previous years among the highest need participants. See Table 12.

Table 12: Point-in-Time Enrollment of Highest Needs Participants by Setting

	NF	HCBS	ERC
November 2005	71 %	25 %	4 %
October 2006	65 %	30 %	6 %
October 2007	60 %	33 %	7 %
October 2008	60 %	33 %	7 %
July 2009	58 %	35 %	7 %
October 2010	57 %	43%	

Source: DAIL Data as of October 2010

Numbers may not add up to 100 due to rounding.

Furthermore, looking at highest needs and high needs individuals, the percentage of those individuals receiving services in HCBS or ERC was 48%, highlighting the ongoing effectiveness of CFC at enhancing HCBS as an option.

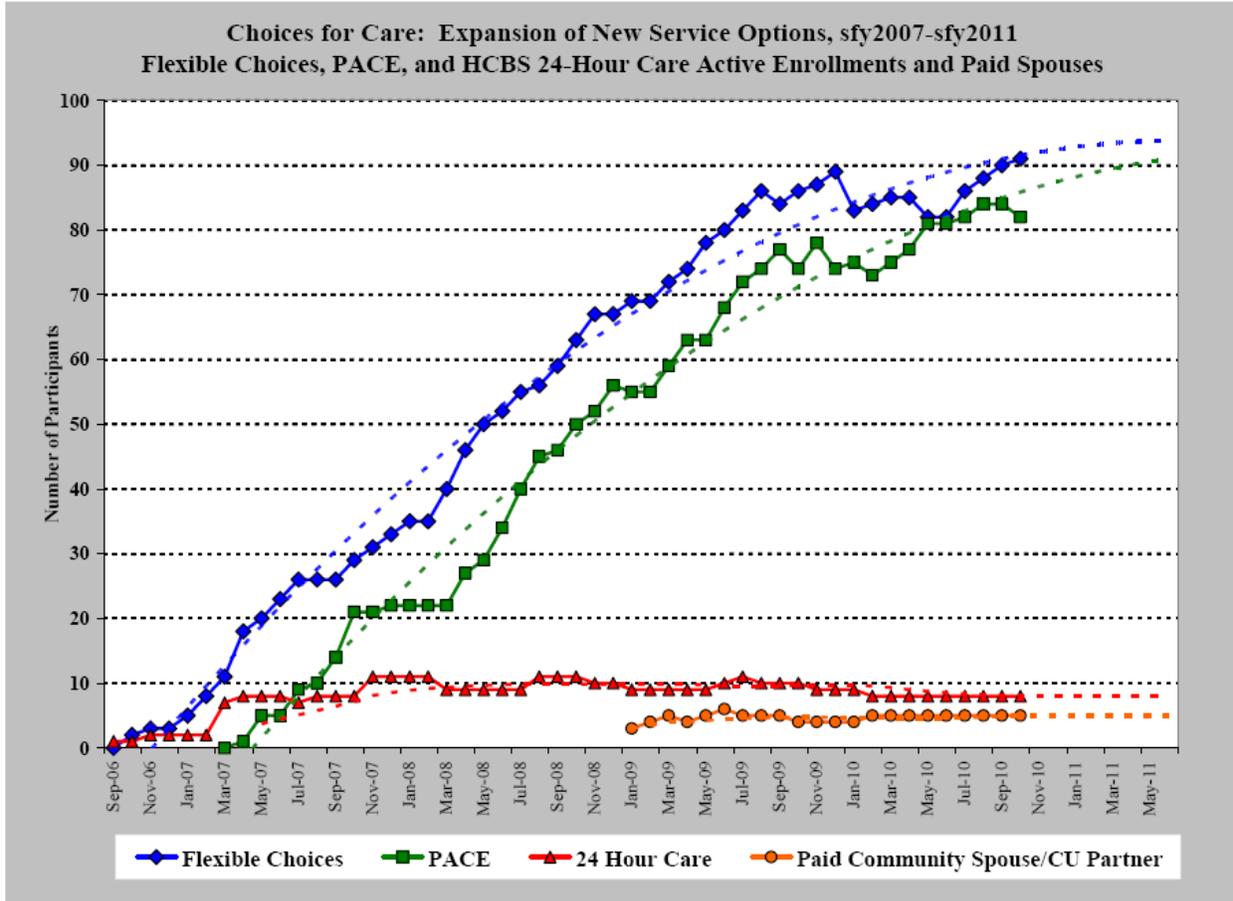
As noted in previous evaluation reports and providing further evidence of HCBS as an option, CFC has implemented and expanded several new service options. These options include:

- **Flexible Choices:** This Cash and Counseling-based option provides participants or their surrogates with a monetary allocation, known as an "allowance" to make a scope of purchases more expansive than any other CFC option. This option can support participants with long-term care needs that cannot be met by traditional services.
- **PACE:** Although this option has experienced numerous challenges such as staffing changes and slow enrollment, this is an evidence-based model that has been shown to improve health outcomes for its participants.
- **24-hour Care:** This model (similar to Adult Foster Care) was piloted as an alternative for individuals who could not be successfully served in HCBS, ERCs, or nursing homes, e.g., former Vermont state hospital patients with mental illness. However, the lack of a reimbursement mechanism for days when

participants are temporarily out of this setting, e.g., during hospitalization or rehabilitation, remains a financial obstacle to the expansion of this service model.

In October 2010, these options were being utilized by about 13% of the highest and high needs individuals being served by HCBS. See Figure 4.

Figure 4. CFC Participants in New Service Options



Source: Market Decisions

D. Experiences with Care

A comprehensive consumer satisfaction survey was completed in 2010. Although the 2010 survey provided data very similar to the surveys conducted in previous years, changes to the content, the collection of data protocol and the assessment methodology were made.

Nonetheless, the survey found that the majority of all DAILE long-term care participants were satisfied with the services they received. Nearly 9 in 10 consumers (89%) rate the quality of help they receive as Excellent or Good, which is similar to past years (2008 and 2009- 91%).

By examining consumers rating of satisfaction with specific program, a more complete understanding of the services is realized. See Table 13.

Table 13: Programs and the rate of Satisfaction

Program	Very or Somewhat Satisfied
Personal Care	98%
Flexible Choices	97%
Homemaker services	94%
Adult Day Center	96%

Source: Market Decisions

Similarly, consumers generally rated the quality of services received from specific programs very high. With the new system of data collection, it was possible to identify specific programs and ratings. See Table 14.

Table 14: Quality of service by Program, 2010

Program	Quality of Service Excellent-Good
Personal Care	97%
Flexible Choices	88%
Homemaker services	89%
Adult Day Center	94%

Source: Market Decisions

E. Quality of Life Outcomes

Long-term supports are often intended to maintain or enhance daily functioning. Therefore, it is crucial that long-term supports be integrated into an individual’s daily life in a way that enables the individual to continue to engage in activities that are deemed meaningful or that contribute to quality of life. Since 2002, DAIL has been measuring quality of life of HCBS participants as well as the general Vermont population.

For this fifth year of the consumer satisfaction survey, a new approach to determining quality of life was adopted. This year, using the survey questions, four quality of life composite variables were developed: Interpersonal QOL, Safety and Mobility QOL, Health QOL and Consumer Satisfaction with Service and Staff. It is instructive that even with the new approach; consumer’s quality of life scores remain lower than those of Vermont residents. The conclusion made in previous evaluation still holds as the data suggests that DAIL consumers see themselves as unhealthy and less satisfied with life. This is suggestive given that HCBS participants include both older and younger people with disabilities and age and disability have been found to relate in different ways to quality of life.

When HCBS participants and Vermonters have been asked about their general quality of life, their ability to be mobile in and out of their home, their contacts with friends and family, and “social lives and connections”, historically, the responses given by CFC consumers to all of the indicators are less than those given by Vermont residents. The data provided in the 2010 consumer satisfaction reflected this trend showing that even as CFC consumers were very satisfied with the services they received, consumers felt that they were less healthy, less safe and mobile, and had lower interpersonal satisfaction, lower social supports and life satisfaction. See Table 15.

Table 15: QOL Indicators rated by Long-term Support Service Consumers and Vermont Residents

Indicator	LTC Consumer	Vermont Residents
Feel part of community	46%	62%
Valued and respected	75%	90%
Satisfied with social life	56%	83%
Someone to count on in case of emergency	89%	95%
Satisfied with how spend free time	67%	87%
Get around inside home	81%	96%
Get where they need to	64%	90%
Feel safe in home	91%	94%

Source: Market Decisions

Although the responses given by long-term support service users are less than those given by the general public there are two particularly noteworthy indicators. There were larger differences between consumers of the long-term support service and the general public related to the ability to get around in the community and to feel integrated in the community. This suggests that issues of transportation and social integration persist. DAHL may want to work with its provider network to explore actions to address these issues.

For individuals needing long-term supports, CFC caregivers constitute sources of important interpersonal experiences, given the personal nature of long-term supports. Caregivers may include a case manager, consultant, or direct care worker. HCBS consumer feedback consistently indicated that workers were courteous and that service quality was good/excellent. For the fifth year, 90% of consumers rated workers reliability as Excellent or Good with 96% rating their courtesy as Excellent or good. The extent to which consumers rate their treatment by their caregiver as courteous and respectful is further supported by the ratings given to individual programs. See Tables 16 and 17.

Table 16: HCBS Consumer Survey Indicators Related to Experiences with Care

HCBS Participant Feedback	Year 1	Year 2	Year 3	Year 4	Year 5
Percent of participants ratings of "good" or "excellent" to survey items:					
"Courtesy of others"	97%	98%	98%	97%	96%

Source: Market Decisions

Table 17: Respect and courtesy by Program, 2010

Program	Caregivers treat with Respect and courtesy Always or Almost always
Personal Care	97%
Flexible Choices	91%
Homemaker services	95%
Adult Day Center	95%

Source: Market Decisions

One response which may benefit from some attention is the fact that overall, 86% of consumers rated as excellent or good how well consumers' concerns or problems are taken care of. When we reviewed the percentage of consumers who said they had a problem which occurred during the previous twelve months, by specific program, the responses is small. However, the rate at which the consumers indicated that their problem or concern was resolved varies. For example, while Homemaker services and Personal Care

services have a higher rate of resolution (68% and 67% respectively), problems with Flexible Choices (while relatively few in number) have a much lower rate of being resolved (32%). See Table 18.

Table 18: percentage of problems and problems resolved

Program	Percent with problem	Percent of resolution
Personal Care	16%	67%
Flexible Choices	19%	32%
Homemaker services	28%	68%
Adult Day Center	10%	52%

Source: Market Decisions

Although this issue appears to affect only a small part of the consumer population, the perception of unresolved problems (as one rudimentary measure of responsiveness by a service provider or a state agency) can potentially have negative impact. In as much as consumers can express their delight with a program, they can also share their negative experiences. DAIL has worked hard to ensure that the CFC program provides quality services to its consumers: the fact that there is a segment who responded that their concern or problem was not taken care of is an issue to which DAIL may wish to pay attention.

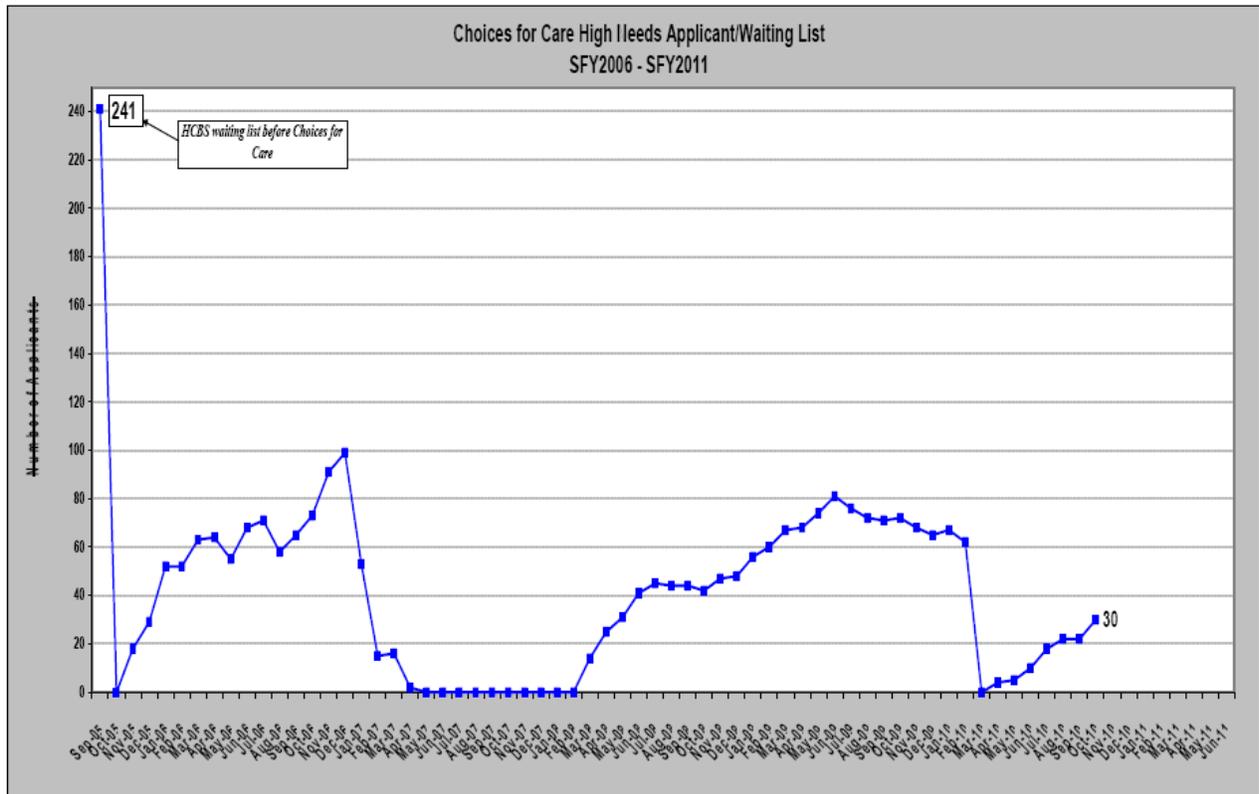
F. Applicant Lists

High Needs Applicant List

As envisioned in the original waiver design, one mechanism that has helped CFC to stay within its budget has been the high needs applicant list. Individuals are maintained on the high needs applicant list only when an applicant list is active *and* as long as they continue to meet high needs clinical criteria. If their clinical profile meets highest needs criteria or if they meet any special circumstances for enrollment (e.g., loss of primary caregiver), they would be enrolled into CFC as a highest needs participant or special circumstance participant, respectively.

When CFC began in 2005, there were 241 persons on the 1915c waiver waiting list (this included both highest needs and high needs). With the commencement of CFC, all individuals who were on the waiver's waiting list were gradually enrolled over the first few months, even though the high needs applicant list continued to be active between October 2005 and December 2006 for new applicants. The high needs applicants list eventually fell to zero in May 2007. In February 2008, the high needs applicant list was reinstated and remained active through October 2010, with 30 people on the list as of October 2010, representing 10 counties. Even though revenues decreased substantially for the state, a few individuals have been able to enroll in CFC. See Figure 5.

Figure 5. High needs applicant list



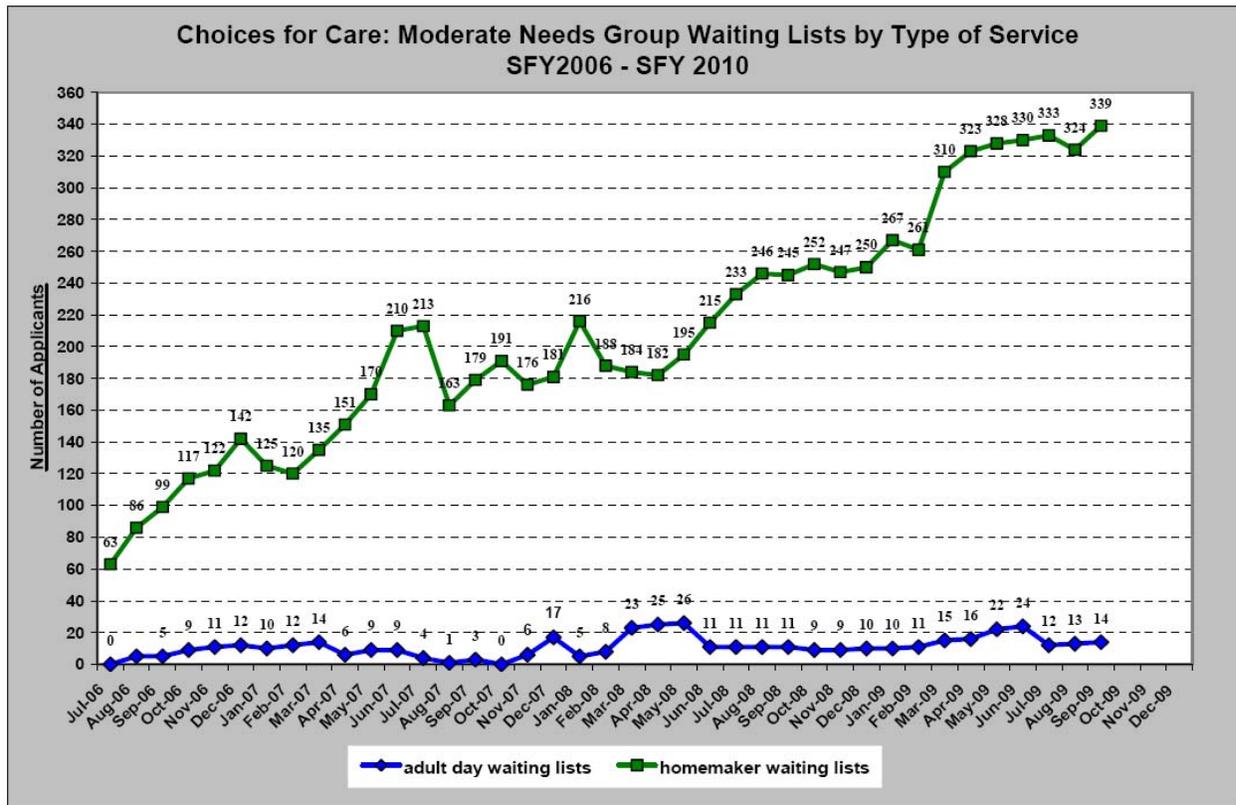
Source: DAIL

Moderate Needs Waiting Lists

The moderate needs group represents an “expansion” group that CFC sought to support in order to prevent or delay nursing facility entries. To be eligible for moderate needs supports (case management, adult day, and homemaker service), an individual could be below nursing facility level of care and could exceed the financial threshold for Medicaid long-term care. As the waiver progressed, moderate needs funding came to serve participants that CFC designers had not originally envisioned. The number of moderate needs participants has also exceeded the anticipated maximum cap of 500 as well. Specifically, moderate needs participants came to include some individuals meeting high needs clinical criteria and financial criteria for Medicaid long-term care but were on the high needs applicant list. This group also includes some people who meet highest needs group clinical eligibility, but are either not eligible for long-term care Medicaid or want to avoid estate recovery requirements. This is consistent with providers’ feedback that “moderate needs” do not properly describe some of their service recipients.

As shown in the figure below, there is more demand for homemaker and adult day services than either funding or provider capacity can meet, mirroring findings from previous years. The numbers of people on applicant lists for both services have remained steady over the past year, 339 to 350 for homemaker and 14 to 9 for adult day services. Also, individuals on the homemaker waiting lists continued to far outpace those on the adult day waiting list. See Figure 6.

Figure 6. Moderate needs applicant list



Source: DAIL

Both of these lists represent measures of unmet need to some extent. However, these measures are only snapshot measures of demand and do not necessarily reflect the actual and real need for services. Some individuals may need CFC services but are never placed on an applicant/waiting list because they don't apply, they don't know to apply, they are able to piece together services to meet their needs to a more or less adequate degree or there is some other reason.

G. Budget Neutrality

Since its implementation of the Waiver DAIL has effectively used its state appropriation to provide services. Despite all of the economic challenges confronting the state, the CFC program maintained its budget neutrality. Previous changes (documented in past evaluation reports) along with maintaining active high needs and moderate needs applicant lists appear to have helped control spending in an uncertain financial environment. At the end of year 5, CFC spending was below appropriations by a wide margin, wider than any other year. Table 19 represents CFC Long-Term Care appropriations and spending only. Table 20 represents CFC appropriations and spending including Acute Care.

Table 19: CFC Long-Term Care

Choice For Care: Long-term care	SFY06	SFY07	SFY08	SFY09	SFY10
Appropriations	\$141,783,616	\$147,512,534	\$163,921,443	\$174,191,109	\$174,214,857
Actual Spending	\$140,087,565	\$147,869,913	\$165,392,741	\$171,852,746	\$169,319,338
% Difference between Actual Spending and Appropriations	1.20%	-0.24%	-0.90%	1.34%	2.81%

Source: DAIL Business Office

Table 20: CFC with Acute Care

Choices for Care (with acute care)	FFY06	FFY07	FFY08	FFY09	FFY10
CMS Projections	\$205,361,772	\$204,107,689	\$224,585,803	\$253,729,888	\$279,323,076
	SFY06	SFY07	SFY08	SFY09	SFY10
Appropriations			\$189,793,638	\$202,456,746	\$199,235,075
Actual Spending	\$154,787,921	\$169,555,756	\$190,510,654	\$197,581,468	\$194,617,477
Actual Spending as a % of CMS Projections	75.37%	83.07%	84.83%	77.87%	69.67%
% Difference between Actual Spending and Appropriations			-0.38%	2.41%	2.32%

Source: DAIL Business Office

H. Public Awareness of Long-Term Care

One of CFC’s goals is to increase general Vermonters’ awareness of long-term care options, analogous to the goal of the “options education” that LTCCCs conduct with new CFC participants. CFC applications data constitute one indirect source of data on Vermonters’ knowledge/desire of long-term care settings at the time when they look to Medicaid to support their long-term care needs. During the five year period, the number of total annual applications to CFC averaged 3704 applications. During the first four years, the number of applications to nursing facilities and that of applications to HCBS were fairly close, with HCBS trailing nursing facility applications by about 4% to 9%. In the last year, the gap widened with 44% of applications to nursing homes and 27% to HCBS. In year five, there were 1309 applications to nursing homes, 788 applications to HCBS and 181 to ERC.

HCBS as a percent of the total remained steady. However, in real numbers, HCBS applications dropped by 204 applications from last year. This real numbers decrease appears to relate to the High needs waiting list. ERC applications remained steady, while applications for the moderate needs group dramatically decreased, mostly likely due to the enrollment freeze.

At the same time, the numbers of applications for which the setting is “undetermined” have risen sharply, from 3% to 20% of all applications in each year. See Table 21. “Undetermined” applications mean applications that either do not indicate a setting being applied for or indicate multiple settings being applied for. There is, in fact, no requirement that an applicant determine a setting upon application. So, these undetermined applications may mean that applicants are not making decisions about an anticipated setting, in effect, keeping options open through clinical eligibility processes. Thus, this percent of undetermined applications may suggest that individuals do not necessarily equate long-term care with nursing facility care. Preliminary comparisons of enrolled setting to applied setting seem to indicate that the undetermined applicants are enrolling in HCBS or ERCs, with the majority of enrolled participants (approximately 60%) in HCBS, ERCs or moderate needs group. It is unclear from the data available what setting individuals were in at time of application; these data would provide another indication of awareness of long-term care choices.

Table 21: Total Number of CFC Applications by Setting

	NF (%)	HCBS (%)	ERC (%)	MNG (%)	Undetermined (%)	Total # of Yearly Applicants
Year 1	41	34	6	16	3	3791
Year 2	37	33	6	16	8	4087
Year 3	36	29	4	17	14	4136
Year 4	36	27	6	14	17	3622
Year 5	44	27	6	4	20	2966

* Percent of total applications for that year.
Source: DAIL

I. Health Outcomes

In 2008, 2009 and 2010, DAIL measured CFC HCBS participants’ self-assessment of their general health. In these years, 50.7%, 48.8% and 46% of CFC HCBS participants reported their “general health” as “good”, “very good” or “excellent”. In contrast, 85.5%, 89.1% and 88% of general Vermonters in 2008, 2009 and 2010 reported their “general health” as “good” or better, respectively. CFC participants have more chronic health conditions than the general Vermont population, and therefore it is not surprising that their reported general health would be less “good”.

IV. Conclusions and Recommendations

Overall, available data has indicated that CFC has been highly effective with HCBS participants, most of whom reported being satisfied with various aspects of the care experiences, e.g., choice and control in planning, quality of services, timeliness of services. In addition, DAIL has shown commitment to ensure that consumers’ input and feedback is integrated in various components of the program.

Even though consumers are overall very satisfied with the program, there are areas which allow for improvements. As one common recommendation, research and additional work by both DAIL and the Evaluation Team on the targets or benchmarks for the below aspects of satisfaction and quality of life will be highly instructive to further assess progress or areas of strength, on the one hand, and areas for improvement, on the other hand.

Information and Dissemination: DAIL provides many of its brochures, forms and manuals on-line. However, in order to proactively increase awareness of its programs and materials, DAIL can work with stakeholders to identify cross-promotional opportunities. For instance, DAIL can determine that each quarter it will place an announcement about its website and the available materials in community newsletters. DAIL can also explore the use of social media- Twitter, Facebook, Blogs. In so doing, DAIL can engage current and future consumers, caregivers and professionals

Access: DAIL can work with community organizations –such as Vermont ADRC and service providers- to increase knowledge of the financial process and eligibility criteria among elders, caregivers, adults with disabilities and professionals who work in the health care field. DAIL can also encourage professionals who assist consumers to complete CFC applications to attend their local Waiver team meetings. These meetings were established to be a forum for community and facility providers to review the status of CFC applications, identify active CFC clients and to exchange information about the application process.

Experience of care: DAIL has established that the CFC program will provide quality services which meet the needs of elders and adults with disabilities who need long-term support services. Consequently, it is incumbent upon DAIL to ensure that all aspects of the CFC program function well. Even though the rate of resolution to problems and concerns indicates that this issue affect a small subset of the overall program, DAIL should work with the staff at all levels that interact with consumers in the specific programs. As noted in the 2010 consumer satisfaction survey, this is currently a small organizational issue which if unaddressed has the potential to become a significant problem because it can grow and have deleterious effect on DAIL's quality of customer service.

Effectiveness/Access: Throughout the years, there has been a gradual closure of nursing facility beds. As more counties begin to provide more services which are community-based, DAIL has the opportunity to explore with stakeholders actions which can be taken by the state to incentivize nursing facilities and others to develop community settings for elders and adults with disabilities. With the growing acceptance of the concept of aging in place, the Green house and Cultural Change movements and the many system change initiatives which are occurring in Vermont and across the United States, this may be the perfect time to work on determining actions which can be taken by the state to encourage and support the provision/building of creative alternative community settings.

Consumer Quality of Life: Throughout the duration of the CFC program, quality of life measures for CFC consumers have always been less than those for the general population. Because these measures include indicators such as health outcomes, community integration, perception of safety and mobility, there are many avenues through which DAIL can act. One option may be that building on its tradition of engaging stakeholders, DAIL may want to work with stakeholders to develop and to implement a plan which can improve the quality of life and satisfaction ratings. As part of this effort, DAIL may want to review its consumer data to determine whether there is a difference in the quality of life and satisfaction ratings by the length of time an individual has received CFC services. DAIL may want to engage Market Decisions to investigate age and disability (specifically the length of disability) and how these concepts relate to quality of life scores. In so doing, DAIL may be able to differentiate some factors which are impacting a consumer's assessment of his/her quality of life and satisfaction ratings. Additionally, because this measure encompasses many indicators, DAIL may also want to identify actions which are readily achievable. For example, it may entail something as simple as Case Managers aiding their consumers to identify someone who they can count on in case of an emergency.

Public Awareness: DAIL is encouraged to review the recommendations provided in the Hospital Discharge Policy Brief and the Consumer Focus groups to determine any actions it can take to increase awareness of long-term support services. As part of determining further action, one other area of public awareness is ripe for additional data collection and analysis. Collecting and analyzing data related to the setting of applicants when they apply, along with the setting they are in when they enroll in CFC, can provide evidence related to awareness, access and effectiveness.

In this fifth year of the CFC program, DAIL met the needs of those Vermonters who need long-term support services. As with any far-reaching program, there are areas which can be improved. However, with an overwhelmingly high rate of consumer satisfaction, DAIL is well positioned to meet the current and future needs of Vermont's elders and adults with disabilities who use the CFC program. This future may include the revisiting of CFC goals and services as health care reform (i.e., single payer models) and dually eligible initiatives are discussed, developed and implemented. Care should be taken by DAIL to ensure that CFC fits within the scope of these potentially larger scale changes.

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