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Vermont Choices for Care

Logic Model and Evaluation Plan Outline First Draft

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Thank you, Steve.

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Section I: Introduction

Background

In October 2005, Vermont launched its Choices for Care (CFC) Medicaid waiver program. This 1115 waiver is an extension of previous initiatives in Vermont to rebalance the state's long-term care system. The goals of CFC are to provide participants with equal access to long-term care options in the community and nursing facilities while preventing unnecessary use of nursing facility care by elders and adults with disabilities who have functional impairments. To achieve this goal, CFC's main objectives are to increase access to home and community-based services while expanding the range of community options as well as providing HCBS early to elders and adults with physical disabilities at potential risk of future nursing facility placement.

More specifically, the type, setting, and amount of waiver services a participant can receive depend on his/her level of need (highest, high, or moderate as defined by the waiver). Specifically, highest needs participants have a choice between nursing home, 24-hour enhanced residential care, or other home and community-based services, without being subject to any kind of waiting list. High needs participants also have this choice subject to available funding. Moderate needs participants (not nursing home eligible) are eligible for more limited home and community-based services and case management support.

Some of the present features of the CFC program had been implemented prior to October 2005, such as the option of enhanced residential care and consumer-direction of some waiver services. Other current features of CFC took effect soon after October 2005. These include the Cash and Counseling-based program called Flexible Choices under the CFC program, the option to pay spouses under the waiver, and 24-hour care. In addition, one of the two PACE providers has begun to enroll participants under CFC.

Objective and Process of Evaluation Plan Development

In meeting federal waiver requirements and assessing their own progress, the Vermont state agency has contracted with the Center for Health Policy and Research, University of Massachusetts Medical School, to develop an evaluation plan. The objective of the evaluation plan is to develop a comprehensive and methodologically sound plan to address evaluation questions that are relevant to the goals, objectives and desired outcomes of the Choices for Care program. The information gathered as described in the evaluation plan is intended to allow Vermont to assess its short-term and long-term progress in achieving program goals and objectives. The full evaluation plan will be available in draft form in late December 2007.

The evaluation plan is designed to meet the needs of different audiences. The primary audiences are the Vermont state agency and the Center for Medicare and Medicaid Services (CMS). The terms and conditions of the waiver approval include an evaluation that contributes to general knowledge of health services delivery and policy-making. At the same time, the program would benefit from periodic feedback data to help make continuous quality improvements. Therefore, the implementation of the evaluation plan is expected to produce knowledge that is generalizable, relevant, and useful to state and federal policymakers as well as state program implementation staff.

To these ends, the following approach was used to develop the evaluation plan. First, we reviewed relevant articles in the scientific literature related to the desired outcomes or areas of state and federal evaluation interest, and how these outcomes have been measured with respect to elders and adults with physical disabilities with functional impairments, such as increased access to long-term care services. We used this information, state and federal policy interests, and Vermont's evaluation goals to inform our development of specific evaluation questions. In developing the specific evaluation questions, we also kept in mind their feasibility with respect to readily available data sources. More specifically, we reviewed existing data gathered by Vermont, CMS, and other researchers to maximize their utility in formulating and possibly answering proposed evaluation questions for the waiver. We then identified key indicators, data collection methods, and analytical approaches for these evaluation questions.

In thinking about data collection strategies, we weighed the utility of gathering quantitative data that was summative in nature with gathering qualitative data where a more exploratory and formative approach could be informative to Vermont. We also sought to minimize the extent to which new or potentially cumbersome data collection methods were necessary but proposed new data collection methods where we felt their potential benefits justified their potential costs. However, an overarching consideration for the data sources proposed in the evaluation is that they may be limited to descriptive analyses unless they can be linked to other CFC participant characteristics to evaluate associations among sub-population groups.

From this process, we summarize our proposed evaluation strategies with respect to each proposed evaluation question and suggest appropriate resources and entities to undertake these tasks.

Section II: Program Logic Model

As an intermediate step to the draft full evaluation plan, two evaluation planning tools have been created to facilitate early general feedback and comments: the logic model (Section II) and the evaluation plan outline (Section III).

The logic model captures, at a high level, the program's desired outcomes and its main ingredients and processes that make these outcomes possible. Specifically, the logic model has several parts: inputs, outputs, activities, and desired short-term and long-term outcomes. These parts are connected by arrows that represent their relationships. "Inputs" denote the entities performing "activities" that are key to the implementation of the Choices for Care program. "Outputs" denote actual services delivered and activities performed through the program, e.g., people are receiving services, program oversight is occurring. "Outcomes" are differentiated by whether these are expected to be observed within the demonstration period (short-term outcomes) or beyond (long-term outcomes).

The logic model serves several purposes. First, it elucidates the mechanics of the program that serve as a starting point for the evaluation. In other words, once the program staff and evaluators have affirmed the goals and objectives of the program, they need to agree on how the program works and its desired outcomes before process and outcome evaluation activities can be initiated. Second, the logic model can be a reference tool for program staff to use in continuous quality improvement efforts. For instance, program staff can anticipate how specific outcomes or processes may be affected if a certain activity is added or modified.

Desired Outcomes for Choices for Care

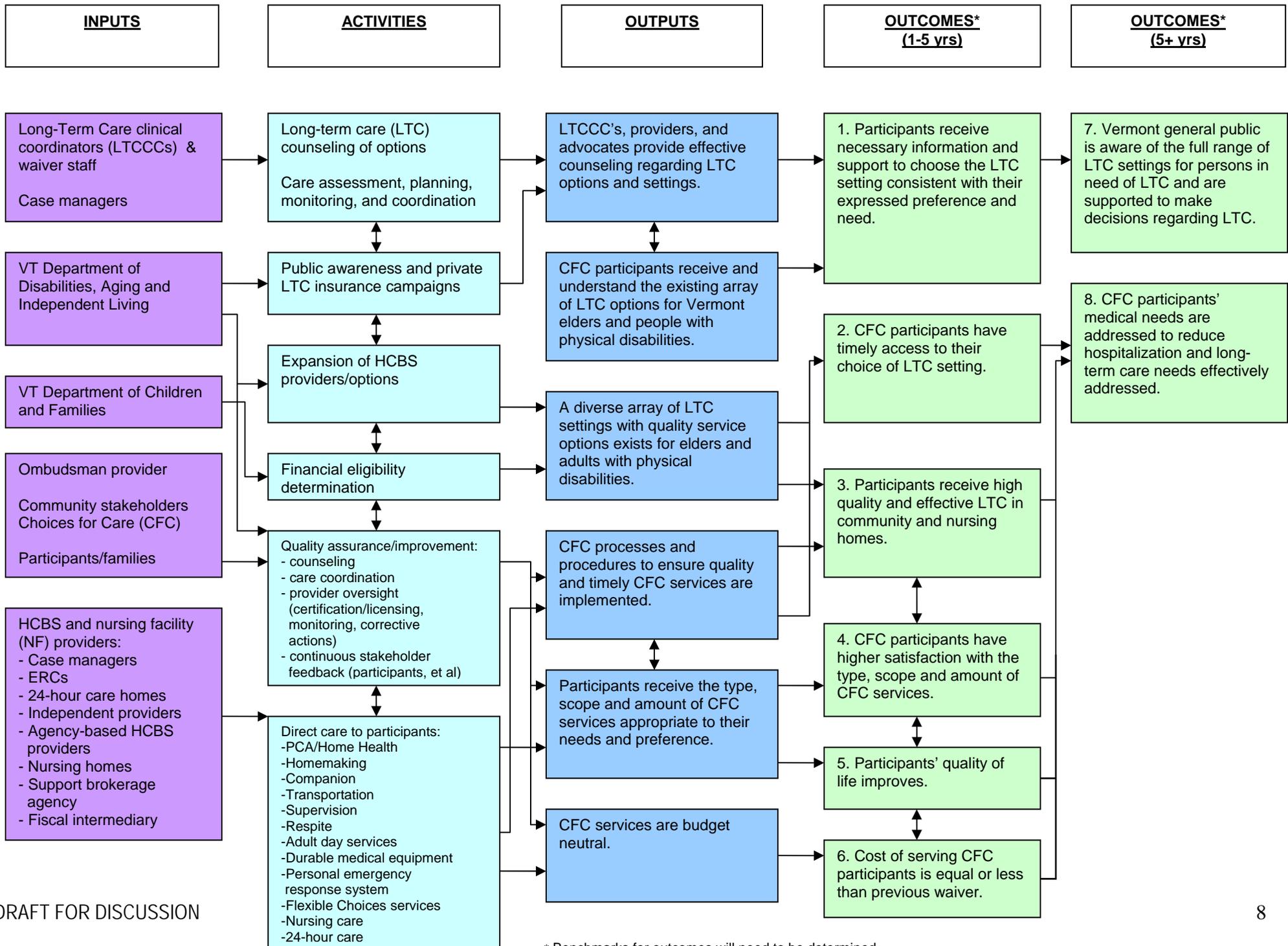
As reflected in the logic model, the Choices for Care program aims to achieve multiple outcomes. The desired outcomes below reflect outcomes to be achieved within the five-year waiver demonstration period (#1 through #6) and outcomes that are expected to be achieved beyond the demonstration period (#7 and #8). In the short-term and long-term, the program hopes to positively affect public knowledge of the long-term care system, expand and improve access to Medicaid long-term care, improve health and satisfaction outcomes, and meet their financial responsibilities to CMS. These outcomes are based on both CMS expectations as well as program objectives the Vermont state agency would like to achieve under the CFC program. The desired outcomes are as follows:

1. Participants and their informal caregivers receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preferences and needs.

2. Participants have timely access to long-term care services in the setting of their choice.
3. Participants receive high quality and effective long-term care services in the community and nursing homes.
4. Participants experience higher satisfaction with the type, scope and amount of CFC services than in previous years.
5. Participants' quality of life improves.
6. Cost of serving CFC participants is equal to or less than the previous waiver.
7. Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and is supported to make decisions regarding long term care.
8. CFC participants' medical needs are addressed to reduce hospitalization and long-term care needs effectively addressed.

It should be noted that because generally agreed upon national benchmarks for these outcomes do not necessarily exist, determining benchmarks against which indicators are assessed will be a critical step in the refinement of the evaluation plan.

Logic Model of Choices for Care



DRAFT FOR DISCUSSION

* Benchmarks for outcomes will need to be determined.

Section III: Evaluation Plan Outline

The desired outcomes in the program logic model form the basis of the evaluation plan outline. Specifically, for each desired outcome, at least one evaluation question and an associated evaluation approach to address the question have been drafted. It is important to note that all desired outcomes are multidimensional, reflecting the broadness of the program and evaluation goals that the program has articulated. As a result, evaluation questions, intended to be feasible within limited time and resources, may not necessarily address every dimension of a desired outcome. Rather, proposed evaluation questions reflect questions that would gather information of high priority in terms of its contribution to general knowledge and its relevance and utility to Vermont's ability to make continuous improvement.

The evaluation plan outline is intended to facilitate a more detailed discussion between the evaluators, Vermont DAIL, and other experts on the evaluation design, methods, and feasibility. Once consensus between Vermont and the evaluators is reached regarding the high-level evaluation plan outline design and methods, further details will be developed and resources identified. To help facilitate this discussion, the following components are presented in the evaluation plan outline and more fully in the evaluation plan:

- Evaluation questions
- Key indicators
- Data sources and collection
- Analytic approach
- Limitations

As noted previously, each evaluation question corresponds to a desired program outcome in the program logic model. Key indicators are described, although more may be identified later. Data sources are identified for each key indicator as are associated data collection methods. The analytic approach explores ways the data could be analyzed. For quantitative data, this likely includes descriptive statistics for the population and their subgroups, associations between variables, and changes over time. Qualitative data would be analyzed for themes. Lastly, methodological limitations for answering evaluation questions are discussed.

Evaluation Plan Outline

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
Desired Outcome 1: Participants receive necessary information and support to choose the long-term care setting consistent with their expressed preferences and assessed needs.				
1A. To what extent are participants' expressed preferences regarding services, self-direction, and settings incorporated in service assessment and planning?	<p>Increase in percent in participants reporting they had enough input when planning for their services</p> <p>Increase in percent of participants reporting that they were involved in making decisions about their help they would receive upon hospital discharge</p> <p>Increase in percent of participants and family members who report that their case managers were responsive to their preferences on setting and service type and caregiver type</p> <p>Participants report that they received information and were involved in decision-making regarding daily</p>	<p>Descriptive statistics from Macro Annual Vermont Consumer Survey</p> <p>Descriptive statistics from Macro Annual Vermont Consumer Survey</p> <p>Annual interviews with participants, family members, providers, and stakeholders</p> <p>Annual interviews with participants and family members</p>	<p>Depending on quantitative data available, experiences with specific preferences can be analyzed for the degree to which they are associated with participant age, gender, diagnosis, living setting, provider type, and case management agency type. Quantitative data will be analyzed to identify statistical changes over time. Qualitative data will be analyzed for themes on promising practices and barriers to implementing participant preferences. Survey samples are representative of the CFC population- and do not readily lend themselves to more discrete analyses. We'd likely need 100% survey method?</p> <p>Consumer survey data can be compared against previous years of consumer survey data (2005 for HCBS participants)</p>	<p>Preferences may change over time. Participants may not be able to recall accurately their past preferences. Participants may not separate their own preferences from those of their family members. For participants with guardians, guardians and participants' preferences may differ.</p>

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
	<p>activities upon hospital discharge</p> <p>Percent of nursing home residents reporting their preferences were supported</p>	<p>Annual interviews with residents and family members</p>	<p>while interview data will be compared to baseline interview data (2007 for HCBS participants). Baseline for nursing home residents has yet to be determined. Look at nf resident survey data (partial participation/data). http://www.dad.state.vt.us/lcinfo/Ressatisfaction/ressatisfislist.htm</p>	
<p>Desired Outcome 2: Vermont elders and adults with physical disabilities with long-term care needs have timely access to long-term care supports regardless of setting.</p>				
<p>2A. Are new CFC participants or NF residents who seek discharge able to receive CFC community services in a timely manner?</p>	<p>Decline in days for clinical and financial eligibility determinations</p> <p>Decline in average number of days from service authorization to service initiation across settings (HCBS, ERCs)</p> <p>Decrease in time elapsed between hospital discharge and receipt of HCBS services for participants discharged to the community</p> <p>Decrease in time elapsed between nursing home</p>	<p>Service application, eligibility determination data in SAMS not reliable</p> <p>Service authorization and initiation date data in SAMS Does not exist</p> <p>Service authorization and initiation date data in SAMS Does not exist</p>	<p>Timeliness of each major CFC process can be analyzed by region, whether participants are new or current, participant needs (e.g., whether cueing/supervision is needed as this can be a difficult group for providers to serve) and whether the participant is transitioning between settings (hospital to home or other settings, nursing home to community, home to ERC).</p> <p>Participant and stakeholder interviews will be analyzed to determine how timeliness affects participants, which process is particularly critical in terms of timeliness, and</p>	<p>We would not be able to assess timeliness for these instances or participants:</p> <p>a) when admissions to nursing homes is “unnecessary”, i.e., participant could have been served by home and community-based services upon hospital discharge, b) when a participant’s nursing home discharge plan is <u>not</u> to discharge to the community due</p>

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
	<p>discharge or start of discharge planning to receipt of HCBS services</p> <p>Increase in percent of participants reporting services are timely</p> <p>Increase in percent of participants who reported specific access barriers, e.g., worker shortage, financial eligibility, etc</p>	<p>Service authorization and initiation date data in SAMS</p> <p>Does not exist</p> <p>Consumer survey</p> <p>Annual interviews with participants, family members, providers, and stakeholders</p>	<p>whether process modifications, if any, work as intended.</p>	<p>to unavailable HCBS, or c) for nursing home residents who do not seek discharge to the community because they are not aware of community alternatives.</p>
<p>2B.To what extent are CFC participants receiving the types and amount of supports consistent with their assessed needs?</p>	<p>Increase in number of cases with service types consistent with needs as identified in assessments and case notes</p> <p>Ratio of average authorized service units to delivered service units for each major service type</p>	<p>Record reviews, including assessments, service plans, service use, (and case management notes as necessary) of a sample of participants.</p> <p>SAMS and EDS</p>	<p>Criteria or data collection instrument would be needed to facilitate case reviews. Analysis of case review outcomes and participant and provider characteristics can be conducted.</p> <p>Administrative data analysis can help identify characteristics and needs of participants that may be under-served or challenging to serve by CFC, such as gender, age, level of need, region (by service type, and diagnosis group).</p>	<p>Participants' expressed preferences and assessed needs may differ.</p> <p>Needs assessed by case managers may differ from assessed needs as determined by DAIL LTC clinical coordinators (LTCCCs) or even the participants.</p>

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
	<p>Participants, family members, providers and stakeholders report that the level of help participants receive, including that to self-direct their services, is adequate or has increased</p> <p>Decrease in number of CFC participants' complaints regarding adequacy of the amount or type of supports</p>	<p>Complaints/Appeals analysis</p> <p>Annual interviews with participants, family members, providers, and stakeholders</p>	<p>Complaints log and interviews can both be used to analyze patterns of complaints and the ability of the program to respond to these complaints.</p>	<p>Some supports identified in assessments may be provided by informal caregivers. Thus, service plan may not reflect full scope of supports a participant might be receiving.</p> <p>Complaints data may not fully reflect concerns if they are under-reported.</p>
Desired Outcome 3: Participants receive high quality and effective long-term supports in the community and nursing homes				
<p>3A. To what extent are participants' long-term care supports coordinated with each other to provide effective care to participants?</p>	<p>Increase in number of participants and key informants who report that effectiveness in coordination among staff has increased</p> <p>Increase in participants whose HCBS providers (case managers, adult day providers, home health, home care, companion, transportation, etc) use the same service plan</p>	<p>Interviews with participants' family members, providers and other key informants</p> <p>Record reviews for selected participants</p>	<p>The purpose of this evaluation question is to assist with clarification of policies, or development of new ones on coordination or services. Until CFC sets expectations, other than those stipulated for case management agencies, regarding coordination of services, the data generated by this question is exploratory, rather than evaluative in nature.</p> <p>Data in 2007 could be analyzed for themes by participant level</p>	<p>Coordination of services will be partially constrained by the fee-for-service financing mechanism of CFC. The financing of "moderate needs" participants is also different from that of the high and highest level participants.</p>

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
			of needs, service setting, and Medicare eligibility status.	
3B. To what extent are community participants' ADL and IADL needs being met?	<p>Increase in percent of participants reporting the "degree to which their services meet their needs"</p> <p>Increase in participants whose assessed needs are addressed in their service plan</p> <p>Decrease in average number of unmet needs within 7 days</p>	<p>Consumer survey</p> <p>Record reviews for a sample of participants in the community or record reviews drawn from reviews (conducted by Quality Man. Unit)</p> <p>Assessment data</p>	We will describe changes across the demonstration years. We will examine participants separately based on the determination of CFC's level of need (highest, high, and moderate).	Paper assessment data will be used until they are available in electronic format. Electronic assessment data may not be reliable but could add to the analysis of this outcome.
3C. Is CFC increasing in its ability to serve participants in highest and high levels of needs in the community?	Increase in percentage of CFC participants living in the community by level of need (high and highest)	Enrollment, eligibility, and residential location data in SAMS	For highest and high levels of needs, we will trace the number of CFC participants from year to year and describe changes in the percentages of participants living in the community over the study period.	Data are cross-sectional view of each year. We will not follow individuals over time.
3D. Is CFC increasing in its ability to serve	Increase in percent of moderate needs participants reporting that	Consumer survey and interviews	Interviews with these participants will be used to explore issues related to	

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
participants with “moderate needs”?	their service meets their needs		service access and CFC effectiveness in delaying the use of more costly services.	
3E. To what extent did Medicaid nursing facility residents’ acuity, as measured by physical and cognitive performance, change over the demonstration period?	<p>Increase in physical and cognitive performance scores* for nursing home residents</p> <p>Reduction in the percent of CFC residents in nursing homes receiving assistance with fewer than 2 ADL needs</p> <p>* Cognitive performance scores increase as functioning decreases.</p>	<p>MDS data for select years</p> <p>SAMS/MDS data for select years, starting with 2003, for which available data exists</p>	<p>We will examine the distribution of physical summary scores and Cognitive Performance Scale across the study period for nursing home residents. We will also examine the distribution of the type of ADL dependence over the study period.</p>	<p>The acuity level, as measured by physical and cognitive performance of nursing facility residents served by CFC, may also be affected by other factors, such as the state population changes, industry supply changes.</p>
Desired Outcome 4: CFC participants’ satisfaction with types, amount, and scope of CFC services improves.				
4A. To what extent are CFC participants experiencing higher satisfaction with types, amount, and scope of CFC services?	<p>Reduction in number of complaints regarding CFC services by setting</p> <p>Increase in percent of participants reporting they are satisfied with CFC service timeliness and quality.</p>	<p>Complaints log</p> <p>Consumer survey</p>	<p>Complaints will be categorized as to whether they are related to service type, amount, or scope and their frequencies by type will be described.</p> <p>We will examine percentage changes in items from the consumer survey. Items for analysis will items on service quality and timeliness. If consumer survey items on CFC service can be summarized in</p>	<p>Number of complaints do not fully reflect concerns that are resolved before they are formally registered or concerns that are unreported.</p> <p>Satisfaction with services is generally</p>

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
			an index, changes in index will be examined across years.	overstated by older persons and this needs to be considered in the interpretation of satisfaction data.
Desired Outcome 5: CFC participants' quality of life improves.				
5A. To what extent did CFC participants' quality of life improve over the demonstration period?	<p>Increase in percent of participants who report an increase in quality of life</p> <p>Increase in percent of participants who report they spend their free time the way they want</p> <p>Caregiver quality of life increases with increased respite services</p>	<p>Consumer survey</p> <p>Consumer survey</p> <p>Interviews with caregivers</p>	Items pertaining to quality of life from the consumer survey (e.g., I can go where I need and want to go) could be assessed for how well they represent the construct for quality of life and whether a sum score could be derived using responses to these items. Associations between consumer survey items on service quality and quality of life could be analyzed.	Unless survey responses can be linked to other participant characteristics (i.e. gender and region) our analysis of survey responses are limited to being descriptive in nature
Desired Outcome 6: The cost of serving CFC participants is equal or less than previous waiver.				
6A. Were the average annual costs of serving CFC participants less than or equal to the projected annual costs for serving this population in the absence of the	<p>Actual annual Medicaid expenditures by CFC do not exceed the projected costs</p> <p>Decrease in percent of actual Medicaid expenditures on NF vs. community services</p>	<p>Medicaid claims data and eligibility data</p> <p>Medicaid claims data</p>	We will analyze per member per month (PMPM) expenditures for CFC participants for major categories of services: outpatient, inpatient, physician services, home health, durable medical equipment, and other long-term care. We will also	Costs of informal supports and housing are not captured for community residents whereas room and board are captured in residential care

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
waiver?	Average annual Medicaid expenditures for each level of need	Medicaid claims data and SAMS	<p>examine relationship between Medicaid expenditures with participant variables such as age, gender, service setting, ADL unmet needs, etc.</p> <p>Medicaid expenditures per client in total and by major categories of services will be traced over the study period. Separate analyses will be conducted for each level of CFC eligibility (highest, high, and moderate need). Total Medicaid expenditures will be compared to the annual projected expenditures. We will also examine the distribution of total expenditures by residential settings, i.e., nursing facility and community.</p>	<p>settings. As many participants are dually eligible for Medicare, current or future Medicare policies could affect how these persons use Medicaid services.</p>
Desired Outcome 7 (Long-Term): Vermont general public is aware of the full range of long-term care settings for persons in need of long-term care and are supported to make decisions regarding long term care.				
7A. To what extent are Vermonters who are hospitalized aware of long-term care setting options at the time of discharge?	Increase in percent of Vermonters who report receiving information on ways to meet their daily activity needs	Consumer survey (questions added for 2007 survey)	<p>For 7A and 7B.</p> <p>Indicators can be compared for CFC participants and other Vermonters.</p>	<p>For 7A and 7B.</p> <p>Data on general Vermonters' or CFC participants' knowledge of long-term care options and their perceptions on</p>

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
7B. To what extent are Vermonters who are hospitalized supported in making decisions regarding how their long-term care needs are met at the time of discharge?	Increase in percent of Vermonters who report being involved in deciding the help they needed to meet their daily activity needs	Consumer survey		being supported to make these decisions are available starting 2007, rather than 2005, when CFC was implemented. Therefore, survey data on these two evaluation questions will be limited to comparisons to data after 2007.
Desired Outcome 8 (Long-term): CFC participants' medical needs are addressed to reduce hospitalization and have their long-term care needs effectively addressed.				
8A. To what extent are CFC participants' medical and LTC needs being effectively addressed?	<p>Increase in percent of participants reporting their LTC needs are adequately addressed</p> <p>Increase in percent of participants whose rating of their general health is "good" or better</p> <p>Increase in percent of participants whose rating of their quality of life is "good" or better</p> <p>Decrease in long-term NF admissions</p>	<p>Consumer Survey</p> <p>Consumer Survey</p> <p>Consumer Survey</p> <p>Medicare/Medicaid claims/diagnosis</p>	<p>We will identify long-term nursing home stay, i.e., length of stay longer than 90 days, from the merged database, and examine changes in the long-term nursing home admission rate by the levels of needs for the CFC determination.</p> <p>We will examine the rate of preventable hospitalizations and trace the pattern over the study period.</p>	Medicare claims data are not readily available

Evaluation Question(s) by Desired Outcome	Key Indicators	Data Sources and Collection	Analytic Approach	Limitations
	Decline in hospitalization rate for specified ambulatory care sensitivity conditions	data Medicare/Medicaid claims/diagnosis data		

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