

Vermont 1115 Waiver Demonstration

Choices for Care Semi Annual Report July 2007 – December 2007

This period marks final quarter of the second year of operation and the first quarter of the third year of the Choices for Care waiver. A description of major accomplishments and activities follows.

As in the last reporting period, enrollments from the High Needs waiting list continued. As of December 31, 2007 there were no people on that waiting list. Careful financial monitoring allowed us to determine that expenditures in the Highest Needs Group were below the anticipated amount and the budget could continue to absorb new High Needs people. This has helped reduce the wait list for the Moderate Needs group by transferring High Needs individuals who had been receiving Moderate Needs service while they waited to come off the High Need wait list.

The Moderate Needs Discussion Group, convened last Spring, finished its review of the Moderate Needs Program. The purpose of the group was to examine the communication process and flow of information. The committee made their recommendations to the Division of Disability and Aging Services (DDAS) Leadership Team who made the final determination of the extent of process changes. These recommendations were accepted and will go into effect on April 1, 2008.

Case Management will continue to be a requirement, as needed, for all Moderate Needs participants, including HASS site participants. Previously Moderate Needs individuals residing in HASS sites were not required to have case management as it appeared to be duplicative. However, the difficulty in communication when individuals transitioned from Moderate Needs to Highest or High Needs was problematic. HASS will continue to provide assistance to moderate needs individuals in concert with the case management service. As in all other groups, the client will determine their Case Management agency through selection at the time of the application.

Initially, the program was designed to allow individuals to access to the program through the adult day or homemaker provider agency. The rationale was that these provider groups managed the limited amount of funds and were

in the best position to determine if funding was available to serve applicants. However, this also was determined to be problematic in terms of communication when an individual applied for Highest or High Needs Group. The Committee determined that all individuals should enter the service through the case management agency in order to better track service changes.

The Case Manager will “take the lead”, meaning they will be responsible for receiving and reviewing applications, verifying funding with the provider agency, conducting the initial assessment after verifying funding, conducting the reassessment, submitting all terminations and change forms to ISU and providers, completing the quarterly contact with each client (via phone or face to face, as determined by the clients’ need. Variances will be given, as needed, for up to 24 hours annually of Case Management services for each client.

Case Management services will be provided for all eligible individuals enrolled in Moderate Needs services, including those who reside in HASS sites. Case Management will only be available through certified case managers that meet DAIL standards. This is no change to the current policy, merely a reaffirmation.

Procedures will be amended to include that providers of service may hold a MNG opening for an individual for up to 60 days due to hospitalization, illness or rehab. After 60 days the applicant MUST reapply for MNG and be treated as if a new applicant. No payment for the individual is made during this time.

The Department continued its efforts in identifying barriers to our ability to appropriately meet the long term care needs of individuals who have particularly challenging complex physical and/or behavioral conditions. These challenging individuals may be persons who are difficult to discharge from the local community hospital and/or from the Vermont State Hospital because there is no other identified appropriate environment that will accept them. Other challenging placements are individuals in the Correctional system that have long term care needs and are close to completing their sentences. As expected, traditional community providers have limited ability and experience in serving individuals with challenging behaviors and complex medical conditions and many nursing homes are reluctant to serve them because of safety concerns and what they characterize as inadequate reimbursement.

An RFP was issued to community providers for state funding to assist in building capacity for a twenty-four hour care system. At the same time, DAIL developed a draft protocol for the implementation of a community-based, individualized 24-hour care system. This protocol was disseminated to

providers, advocates, legal aid, and consumers for input into its final design. Two focus groups were also held. DAIL staff is now in the process of establishing policy and procedural guidelines for this new service option.

In the meantime, individuals remained in needs of “wrap around” service”. Of particular note was the interest of DAIL providers who traditionally served only the developmentally disabled population. Some of these providers came to the fore to design and serve these challenging placements. To date, DAIL has partnered with nine (9) agencies to successfully serve 16 individuals. DAIL continues meeting with the Long Term Care Task Force led by the Director of the Individual Supports Unit. This committee is charged with undertaking an examination of the challenges and barriers to meeting the unique needs of these individuals. The Committee is currently examining the challenges that contribute to discharge delays from acute care facilities and will recommend solutions.

A Real Choices System Change grant in the Community Development Unit of DAIL is looking at creating an integrated system of care for acute/primary care and long term care service delivery for elders who are frail, at-risk or chronically ill and adults with physical disabilities. This project is similar to a rural PACE model and has been named “ MyCare”. An RFP has been issued for providers to develop business plans to determine the feasibility of their organizations providing integrated services. If successful, this option is anticipated to be rolled into Choices for Care as a service option similar to PACE Vermont.

The Quality Management Unit is responsible for monitoring the Choices for Care providers (excluding Enhanced Residential Care and nursing facilities, which are surveyed by the Division of Licensing and Protection). Beginning in July, 2007 the Quality Management Plan and its processes were implemented. During this reporting period, five (5) Choices for Care (CFC) service providers and 55 participants were reviewed.

The reports are comprised of three areas of review: (1) Quality Services Reports which convey the manner in which DAIL documents outcomes for service providers and participants; (2) Quality Action Plans which describe areas for change and how service providers will make improvements to services based on the Quality Services Reviews; and (3) a summary of participant responses to individual interview questions. A sample copy of one of the reviews is attached to this report as Appendix A.

During the first six month of implementation it was apparent that the Quality Management Plan required a change regarding the language that is used to categorize review findings. The current language is confusing and caused a need for additional time for review staff. Over the next several months, the Quality Management unit will establish a committee to look at different language or categories.

Three major areas for improvement have emerged as trends across providers. First, several CFC service providers are finding it difficult to provide “Person-Centered Practices” as described in the Quality Management Plan outcomes. This issue is broad and is currently being addressed within all the Waiver programs in DAIL. Second, case managers have had difficulty in complying with all of the requirements of the Case Management Action Plan, which requires clear, measurable, and individualized goals. In response, the Quality Management Unit developed an informative guide for case managers. As a result, we have seen case manager certification exam scores improve. Third, agencies appear to need technical assistance in including participants in many of their organizational processes.

Flexible Choices is Vermont’s Cash and Counseling model, in which an individual’s service plan is translated into a person-centered budget. This Choices for Care option is available to individuals who are currently participating in the consumer- or surrogate-directed service option under Choices for Care. The Flexible Choices option allows for more flexibility in purchasing services and goods that the individual feels will meet his/her unique needs. These are often services and goods that are not available under the “traditional” program, but are necessary to the care and support for the individual.

Flexible Choices continues to see slow but steady growth in the number of individuals who choose this option. As of December 31, 2007 there were 33 current enrollees. A total of 40 individuals enrolled since the inception of the program. Six individuals left the program – two (2) due to death, two (2) decided this option was not the right fit for them, and two (2) entered a nursing home.

Despite the continuing disappointing numbers, several trends suggest that growth will continue. The staff at Transition II (the contracted consultants) sponsored a “Flexible Choices Fair” in one county and intends to conduct three more throughout the state by July, 2008. Transition II has also been actively reaching out to case managers of Choices for Care and are beginning to receive

a more positive response than at the program's start. Finally, Transition II continues to experience a very high "conversion rate": meaning that of the people with whom they conduct home visits, approximately 90% enroll in the program. We project continued, slow growth at a rate of 2-4 new enrollees per month.

PACE VERMONT opened its door on April 1, 2007. Total enrollment as of January 1, 2008 was 23. This is behind the initial projections which suggested a census increase of four (4) clients per month during the first year of operations. Enrollment for November was one (1) new client; for December was (1) new client. PACE Vermont maintains that their initial projections regarding enrollment numbers are not reliable as these projections were based on PACE programs starting up in urban areas as opposed to PACE Vermont which is starting up in a more suburban setting.

A particular challenge as viewed by PACE Vermont is the cutoff date for Medicaid processing. This date is the 15th of the month prior to enrollment. PACE Vermont offers that this creates delays in start dates. This may result in a potential enrollee selecting other Choices for Care options where providers can admit immediately and receive retroactive payments within the fee for service system.

Another challenge is that Vermont offers many attractive options for clients to receive their Long Term Care services. Competition between these different options makes it more challenging for PACE Vermont to attract clients. Added to this is the option in Choices for Care for participants to hire their own personal care attendants under the consumer- or surrogate-directed option. PACE Vermont sees this as their most direct competition. As a result, PACE Vermont is examining ways into which they might be able to adapt service plans to more closely mirror this option.

The Colchester site has had significant challenges in staffing and organization. Since opening in April, PACE Vermont has had turnover in their Home Care Coordination, Center Manager, Executive Assistant, Administrative and fiscal services manager as well as the LNA/PCA staff and therapy staff. As of the end of this reporting period, the Colchester site is still recruiting for a Home Care Coordinator as well as an Occupational Therapist.

PACE Vermont has been undertaking extensive marketing activities. The majority of referrals continue to come from providers (including physicians, home health agencies, Area Agencies on Aging, and the Long Term Care

Clinical Coordinators. Future initiatives will focus on connecting directly with communities' potential participants through aging expositions; social gathering places such as faith-based organizations as well as the distribution of brochures at sites where elders gather.

During the last quarter of 2007, the Rutland site finished construction. In September the site underwent a readiness review by the State of Vermont. The Rutland site passed the State's review as well as a review by CMS and was given the go-ahead to become operational in October 1, 2007. PACE Vermont publicly announced that they will be open for enrollment February, 1, 2008. According to PACE Vermont the delay between October and February was a result of staffing challenges for the Rutland site. As of this report, all necessary staff have been hired or contracted for with the exception of the Transportation Coordinator/Administrative Assistant position.

The Rutland PACE staff have been provided interdisciplinary team (IDT) training during this past quarter and the Vermont State Department for Children and Families – long term care financial specialist - have been provided training in the PACE model of care.

On June 15, 2007 a contract was awarded to the University of Massachusetts Medical School, Center for Health Policy and Research (CHPR), to undertake the evaluation of Choices for Care. The contract requires a multi-level approach. CHPR, working with the University of Vermont, have completed focus groups and interviews of consumers, family members, providers, and state staff. These focus groups are intended to identify and elucidate issues related to the implementation and management of Choices for Care. Written reports are due in February, 2008. Additionally, CHPR completed a logic model and evaluation plan to guide the Choices for Care evaluation. The evaluation plan includes the Choices for Care goals, evaluation goals, and performance indicators, system outcomes and measures, consumer outcomes and measures, a strategy for identifying predictors of nursing home use, methods of data collection, and methods of data analysis. This document is intended to contribute to discussion and input into the development of the evaluation plan. A copy of this plan is included as Appendix B.

As part of the evaluation contract, CHPR provides some technical assistance. The contract requires that they conduct a review of policies and procedures related to Choice for Care eligibility, enrollment, and service authorization, service delivery, and quality management. Based on this review and discussions

with State staff, the contractor will summarize observations and document recommendation and possible action steps in five (5) 'policy briefs' reports related these five topics.

The first brief, related to *Eligibility*, asks the following questions:

- *What are the major design issues for implementing presumptive eligibility?

- *What mechanism exists to inform new and existing CFC participants of community options and how can this mechanism be improved to ensure participant knowledge/awareness/retention of community options?

The *Enrollment* policy brief will look at the following questions:

- *To what extent is the enrollment process timely and understandable for enrollees and what improvements could be made?

- *What information and support do participants have to make decisions regarding service options and whether to self-direct their care, and how improvements could be made to better support participants?

The policy brief on *Assessment and Service Authorization* questions are:

- * To what extent is the assessment tool effective in documenting key outcomes and how could the assessment process be improved?

- * To what extent are medical and long-term care needs identified in assessments addressed by CFC providers?

- * What information is provided to the participant about service options during service planning and how much is the participant involved in which services are authorized? What, if any, improvements can be made in this process?

The *Service Delivery* brief questions are:

- * What types of support are useful to participants in consumer/surrogate directed care, what extent are those supports provided to CFC participants, and how can CFC improve the amount and type of support to self-directing participants?

- * How are services coordinated among different HCSB providers and what options exist to strengthen this coordination?

The *Quality Management* policy brief will examine:

- * To what extent does the CFC quality monitoring system include the structure, process, and outcome measures, as well as participant-identified outcomes as well as clinical outcomes?

* What additional indicators could be adopted in the CFC quality Management Plan to address outcomes of interest?

CHPR staff are now working on the third draft of the eligibility brief.

Programmatic date is included as Appendix C.

DAIL is required to report to the State Legislature on spending to the Health Access Oversight Committee when the legislature is not in session. Early in the state fiscal year, expenditures were running lower than anticipated. However, during November-December 2007 expenditures tracking shows that if kept unabated, CFC expenditures would exceed our appropriated budget. This is being closely tracked and the need for a High Needs waiting list was being considered in December.