

# **One to One: Vermonters in Transition**

Vermont Agency of Human Services  
Department of Aging and Disabilities  
Department of Social Welfare: Medicaid

July 20, 1999

## **EXECUTIVE SUMMARY**

The state of Vermont is poised to take full advantage of HCFA's "Nursing Home Transitions Initiative." Using new screening and identification tools, Vermont's "*One to One*" project will target specific nursing home residents living in selected areas of the state. Specialized case managers, working as members of integrated, multi-disciplinary case management teams, will offer education, support, and counseling to nursing home residents who wish to move to a community setting.

The bulk of Vermont's grant funds will be used to provide case management and 'wraparound' services to Vermonters currently residing in nursing facilities but unable to leave due to current fragmentation and gaps in the continuum of care.

The project's three primary objectives are to:

- help over 8% of Vermont's Medicaid beneficiaries who are residents of nursing homes move into a community-based setting;
- improve the rate and number of Medicaid beneficiaries with a "High Potential for Community Placement" who successfully transition to a community setting;
- target the "residual" Medicaid nursing home population and help them transition to community settings while gaining the information necessary to design new programs, interventions and provider performance standards for this population.

During the project timeframe, an estimated 190 nursing home residents, representing 8.28% of Vermont's nursing home Medicaid population, will transition to a community setting. Project costs are estimated at approximately \$2,190,000, with \$499,200 in grant funds. First year cost savings, due to avoided costs, are estimated at \$1,480,000 net of all expenses.

## **NARRATIVE DESCRIPTION:**

### **Current Status:**

Vermont is a small northern New England state with a population of 588,978, with 72,213, or 12.3% of the total population, over the age of 65. A 1993 survey conducted by AARP indicated that 97% of Vermont's older population would prefer to receive their long term care at home. Despite popular opinion at that time, over 90% of Vermont's long-term care dollars were spent on institutional care. State policy makers faced two stark realities.

- Continued reliance on traditional models of care, including institutional models of care that the public does not want and the government cannot afford, will not succeed.
- Continued dependence on a fragmented system, in which each provider looks at single issues and acts only in its own self-interest, does not benefit the consumer, nor is it sustainable.

A national pioneer in developing community-based systems of care for people with developmental disabilities and/or traumatic brain injuries, in 1996 Vermont passed landmark legislation to reform its long term care system. Act 160 requires Vermont's Agency of Human Services (AHS) to:

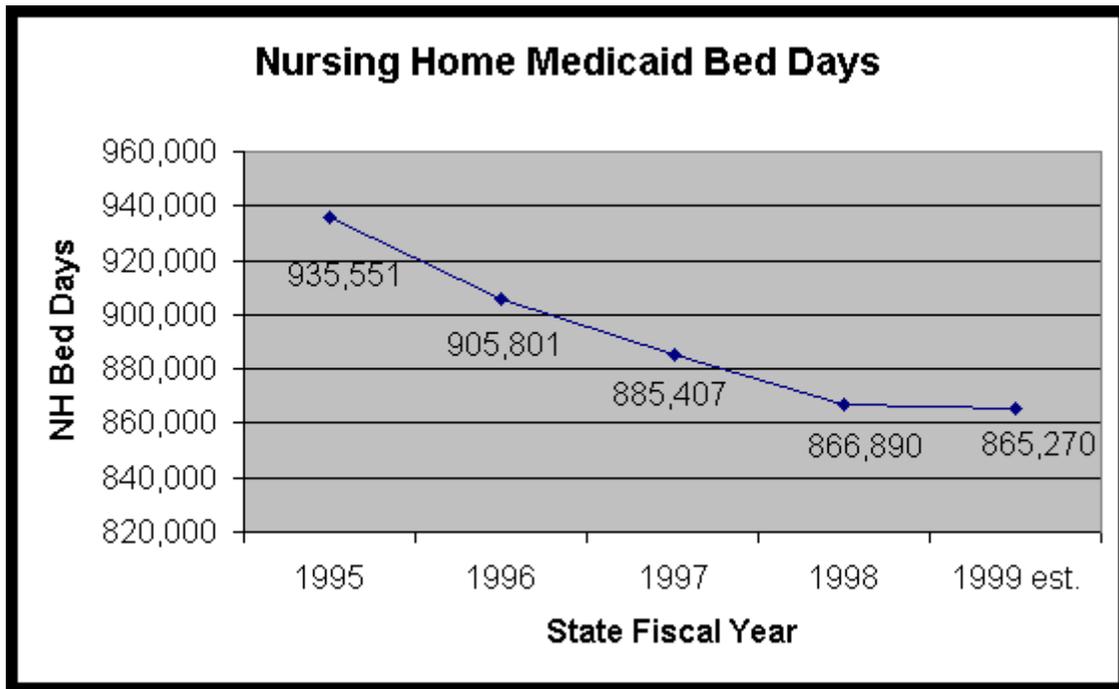
- improve the state's independent living options for vulnerable elders and younger people with physical disabilities;
- slow the growth of its nursing home budget;
- redirect these dollars into home and community-based services, "with consumer participation and oversight...in the planning and delivery of long term care services."

Over the course of four years, an estimated \$18 million in Medicaid reimbursement was projected to shift from nursing home care to providing education and independent living options to Vermonters, so that they might live with dignity and independence in settings they prefer. The legislature also required that AHS "... implement a statewide system of long term care...to minimize administrative costs...improve access...and minimize obstacles to the delivery of long term care services to people in need."

Vermont's recent history in long term care has been punctuated by:

- a vigorous expansion in service opportunities for people meeting nursing home level of care criteria;
- a steady decrease in Medicaid nursing home bed days, tempered by FY99 changes in federal Medicare reimbursement policy;
- increasing sophistication in the administrative protocols governing home and community-based services;
- the lowest nursing home occupancy in Vermont's history (91%). Despite this decline, Vermont is still at the national median for nursing home occupancy;
- regional community-based coalitions beginning to assume leadership roles in planning and managing a long term care system which promotes people with disabilities living with independence and dignity in settings they prefer.

In the past four years, Medicaid nursing home bed days have declined dramatically. While a change in federal Medicare policy affecting home health services for "homebound" individuals created an upswing in demand for nursing homes in Vermont during FY99, Medicaid utilization has once again begun to decline.

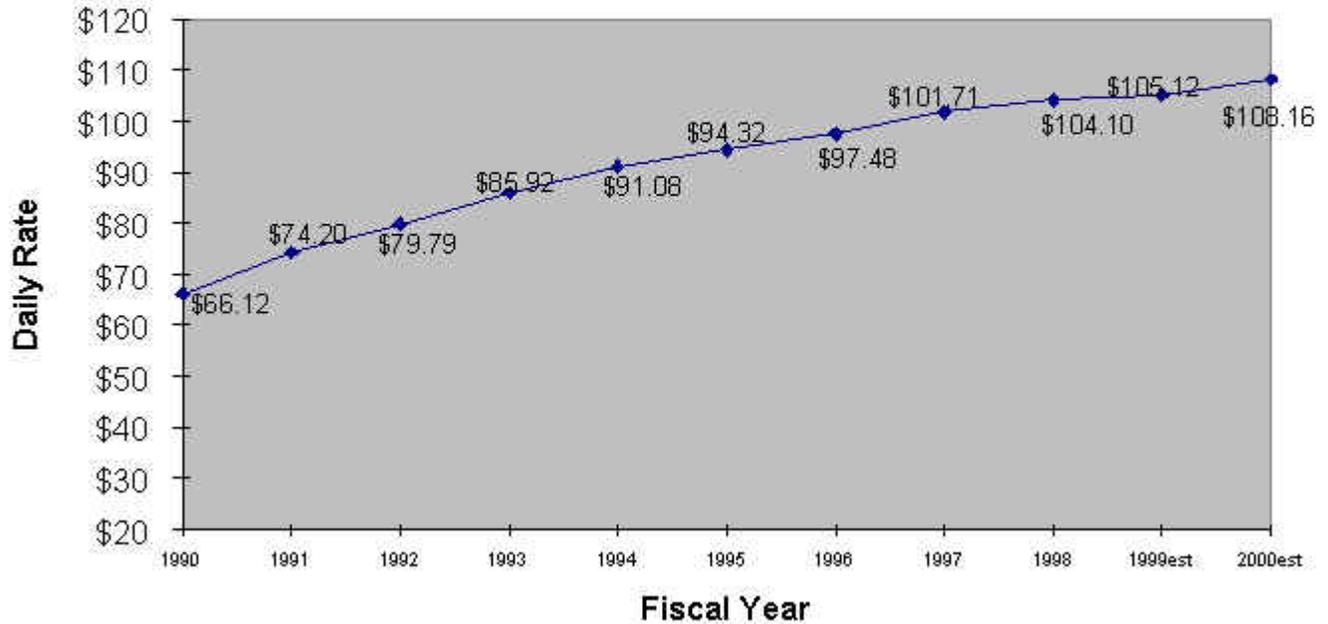


As utilization decreased, Vermont took advantage of the pending sunset of reimbursement rules to revise the nursing home reimbursement methodology. After meeting with a broad group of industry representatives for six months, the state adopted a methodology which:

- includes only the case mix scores of a facility's Medicaid residents in determining a facility's average case mix score, which is used to establish a quarterly Medicaid per diem reimbursement;
- modified its classification system and now uses the complete federal RUGs-44 groupings as opposed to a RUGs-29 system modified only for Vermont;
- eliminates return on equity as an allowable cost;
- modified the "efficiency incentive" to become, over a three year period, a "quality incentive" based on survey results and reports of consumer satisfaction; and
- removed the General Operating Limits.

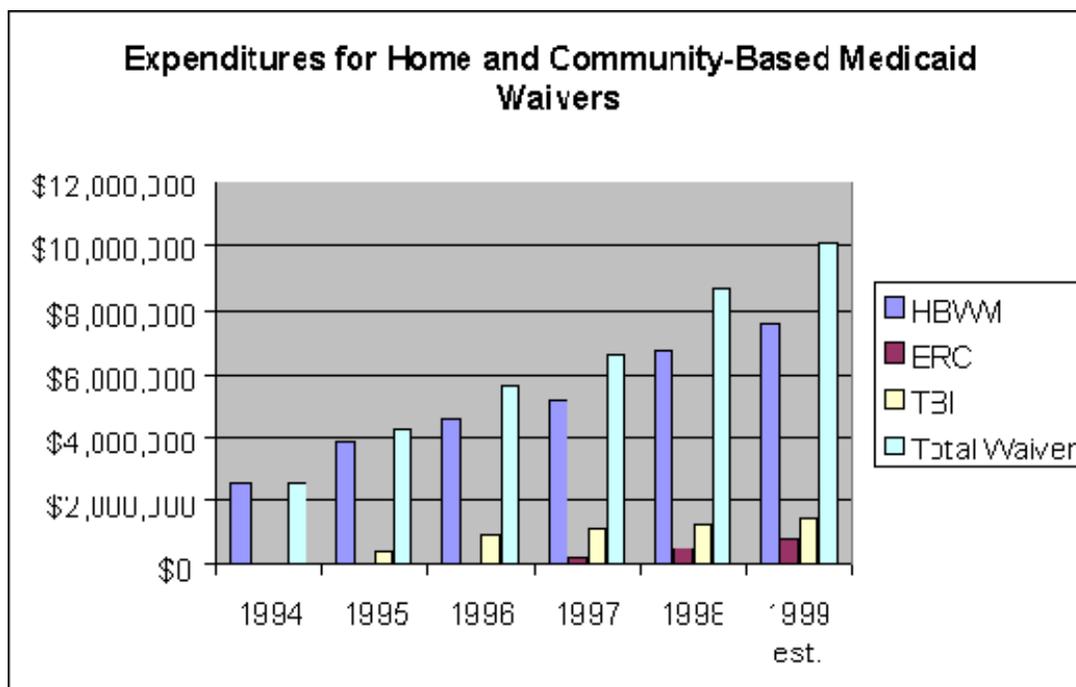
The methodology, designed to provide greater equity and utilize national standards, was also projected to slow the nursing home rate of per diem growth.

### Average Medicaid Daily Rate\* for Nursing Home Beds



Additionally, AHS has entertained discussions and conducted negotiations with industry representatives and individual owners to remove beds from the state's supply. To date 82 of Vermont's 3624 nursing home beds have come "off-line". While Act 160 anticipated the potential of bed delicensure, to date the state has adopted a fairly "laissez faire" attitude, letting market forces play out. Three facilities, representing 100 beds, are currently exploring diversification or closure with the state and/or their regional long-term care coalitions.

The 7.5% decline in annual Medicaid bed day utilization over five years, combined with changes in the nursing home reimbursement methodology, has allowed community-based services to expand, including the Aged and Disabled Medicaid Waiver, (HBMW) program, and a new Enhanced Residential Care Medicaid Waiver (ERCMW). Total expenditures for Vermont's Waiver programs grew 380%, from \$2,620,000 in FY94 to an estimated \$9,970,000 in FY99.



Reflecting the values and principles of Act 160, Vermont has worked to develop a community-based long-term care system which is consumer-centered and individualized. Vermont's current system demonstrates a significant investment in the health and well-being of the state's Medicaid population. Elderly and disabled beneficiaries have access to dental, hearing aid, vision, pharmaceutical, chiropractic, DME, diabetic supplies, home health nursing, hospice, immunizations, nutrition therapy, organ transplants, physical therapy, psychiatry and psychology, respiratory therapy, speech therapy, substance abuse treatments and transportation benefits in addition to primary care coverage.

Additionally, new Assistive Community Cares (ACCS) service and a new Adult Day Rehabilitation State Plan service, supporting personal care and nursing oversight in residential care homes have been added. Nursing home coverage remains in effect. Beneficiaries also access nutritional programs such as nutritional counseling and home-delivered meals, homemaker services, peer counseling through the Vermont Center for Independent Living, home modification programs and assistive technology, Senior Companion programs and advocacy programs through the area agencies on aging.

The core community services available to people with high levels of need in Vermont's system are:

- *Case Management:* Case managers employed by area agencies on aging and certified home health agencies assist consumers in accessing necessary and appropriate services and monitoring the efficacy of those services.
- *Adult Day Services:* Adult day programs throughout the state provide personal care, rehabilitation, nursing oversight, socialization, and respite care services.
- *Attendant Services Program:* This program provides consumer-directed personal care services and is managed and directed, on a voluntary basis, by consumers.
- *Home-Based Medicaid Waive :* HBMW provides case management, personal care, adult day, respite care, and assistive devices and home modifications. This waiver includes consumer-directed, surrogate-directed, and agency-managed service options.
- *Enhanced Residential Care Medicaid Waiver Services:* ERC provides case management and Enhanced Residential Care services in high quality residential care homes.

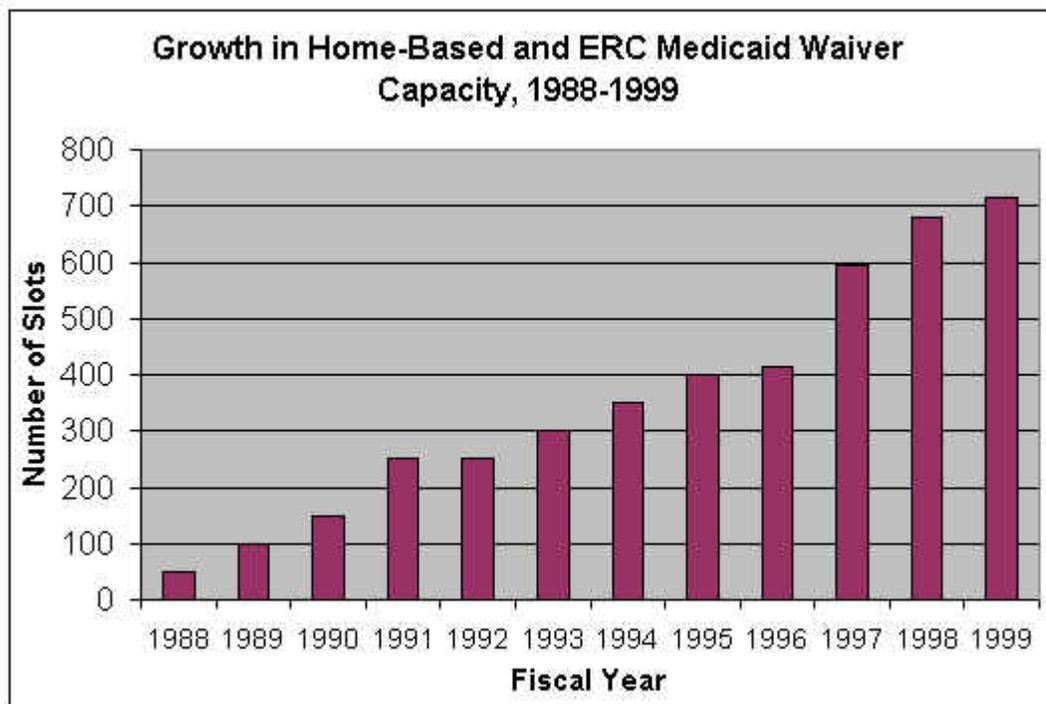
Vermont is committed to providing individualized services to people with high levels of need. This commitment is reflected in the continued growth in service capacity, in conscious efforts to "prioritize" services for people with the highest levels of need, and in the continued development of new service options.

Growth in capacity:

Vermont has committed increasing resources to the programs that serve people with the highest levels of need. Financial growth in selected programs is shown in the following table:

	SFY1997	SFY2000	\$	%
	Actual Expenses	Estimated Expenses	Increase	Increase
Adult Day Services	\$ 665,687	\$ 1,054,802	\$ 389,115	58%
Attendant Services Program	\$1,803,595	\$ 2,959,266	\$ 1,155,671	64%
Home-Based Medicaid Waiver	\$5,199,902	\$12,195,615	\$ 6,995,713	135%
Enhanced Residential Care Medicaid Waiver	\$ 219,045	\$ 983,450	\$ 764,405	349%

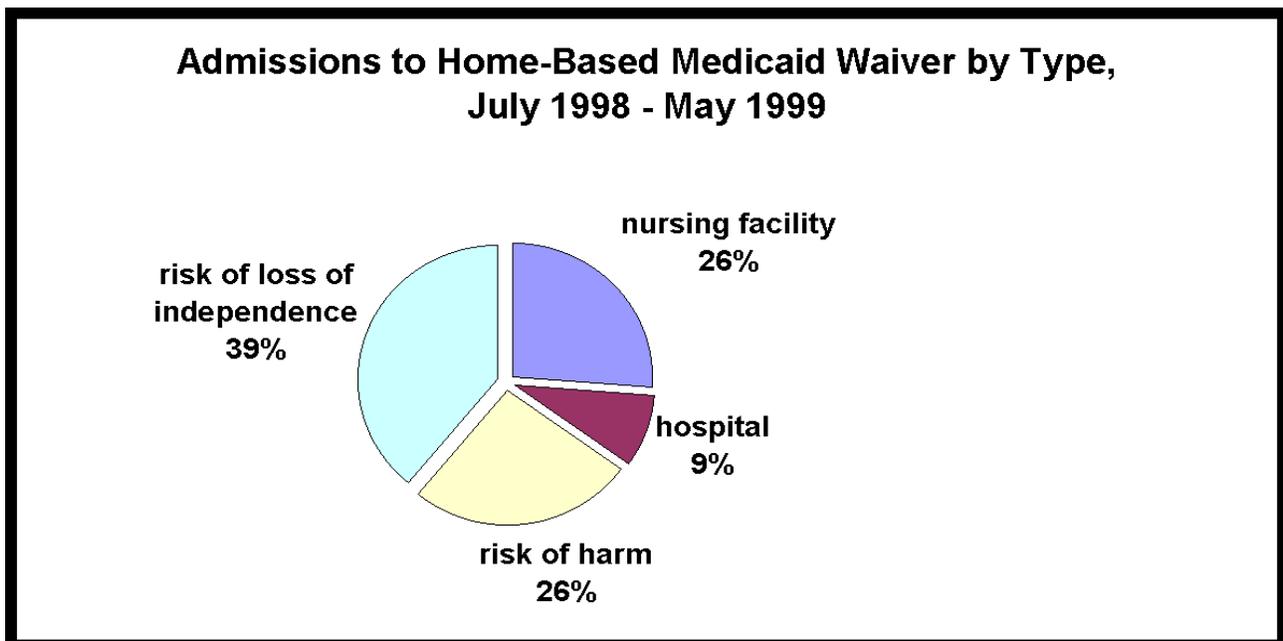
Growth in the HCBW and ERCMW has been dramatic, increasing from 50 slots in 1988 to over 700 slots in FY99. Another 125 slots are scheduled to be added in FY00. "Priority" Medicaid beneficiaries, as defined below, will use all waiver slots.



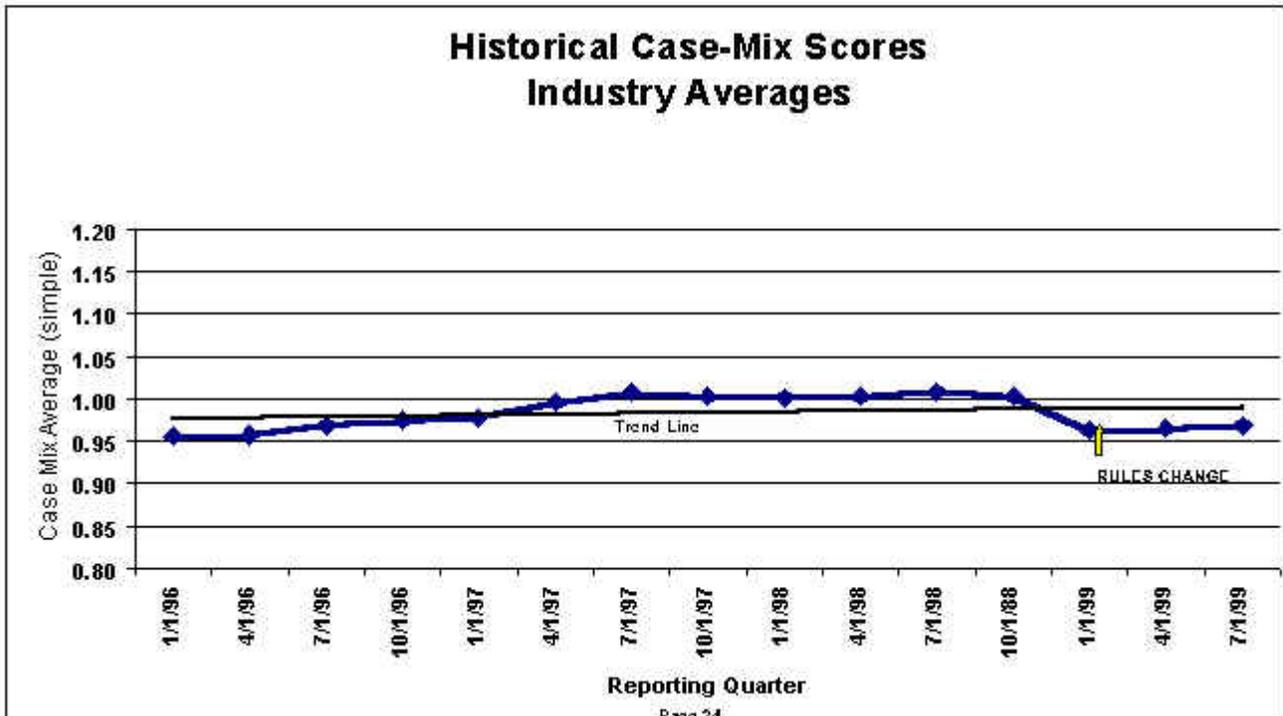
Prioritization: Recognizing that the continued use of chronological waiting lists meant that those in greatest need of services were often never served, Vermont implemented "prioritization" procedures for applicants to the Home-Based Medicaid Waiver in November, 1997. In March 1999, procedures were implemented for applicants to the Enhanced Residential Care Medicaid Waiver. Developed in collaboration with local case managers and Medicaid Waiver services providers, the prioritization procedures give priority access to Medicaid Waiver services to four applicant groups:

1. applicants who are in a nursing home, wish to be discharged to a home and community-based setting, and cannot do so unless waiver services are provided;
2. applicants who are in a hospital, wish to be discharged to a home and community-based setting, and who would be admitted to a nursing home unless waiver services are provided;
3. applicants who are at risk of significant harm unless waiver services are provided; or
4. applicants who are at risk of losing their independence (i.e. moving to a more restrictive setting) unless waiver services are provided.

Local case managers and 12 interagency Medicaid Waiver Teams manage prioritization and regional waiver resources. Using an assessment and scoring methodology, the teams prioritize individuals within the four "priority groups", ensuring that those applicants with the highest level of need are able to access appropriate services in the region. The combination of growth in waiver service capacity and regional prioritization has helped to provide more timely access to services for people who are at greatest risk of nursing home admission, and to an increasing number of current nursing home residents. Historically, fewer than 5% of individuals admitted to waiver services were admitted from nursing home or hospital settings. That figure has changed significantly due to prioritization. The following chart illustrates changes in the source of admission for all new applicants admitted to Home-Based Medicaid Waiver services for the period July 1998 through May 1999 (N=367).



Waiver participants' average acuity scores (based on activities of daily living, instrumental activities of daily living and cognition), increased by 17.4% from 1997 to 1999. Acuity scores for nursing home residents also increased, but are somewhat distorted. Average case mix scores prior to 1/1/99 reflect the entire nursing home population. After 1/1/99, they reflect the "Medicaid only" population.



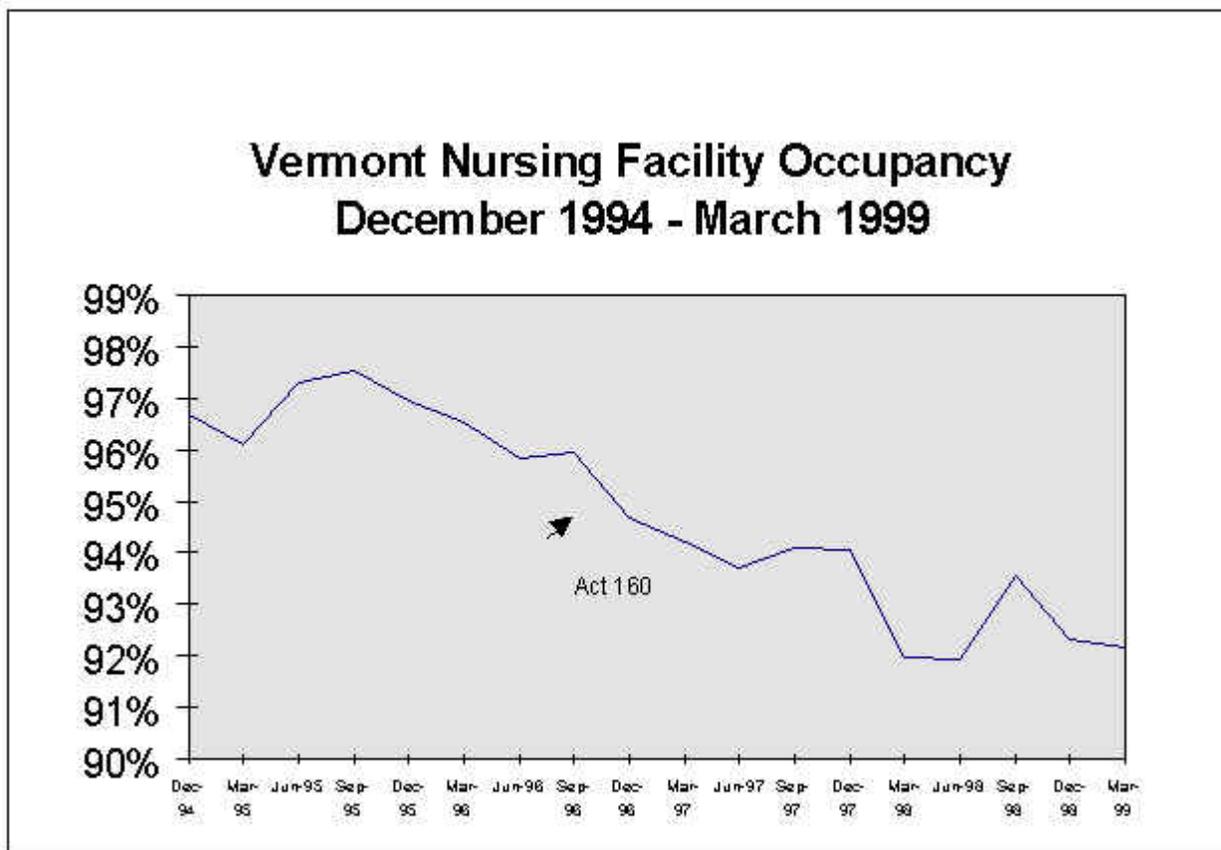
In an effort to test new ways to identify, educate and assist Medicaid nursing home residents in achieving their expressed desire to return to the community, Vermont initiated a pilot project in one county to change Medicaid nursing home utilization review/level of care (UR/LOC) procedures in July, 1999. This pilot project supports local home health agency nursing staff in performing UR/LOC reviews for all Medicaid nursing home residents in all facilities within the region. UR/LOC staff will identify residents who would like to return to the community, educate them concerning their alternatives and link them with case managers who will provide assistance. This pilot project will be expanded to include other *One to One* regions, providing support to case managers and to the new *One to One* initiative.

Partnerships

Vermont has developed two forms of partnerships in order to help achieve our shared goal of helping elders and people with disabilities live with dignity and independence in the settings they prefer. The Medicaid Waiver teams, active in each area of the state, act as interdisciplinary case management teams, seeking out individuals who may be eligible for the Medicaid Waiver programs, assisting with applications, performing assessments, prioritizing cases and sharing resources to support consumers.

The Department of Aging and Disabilities has also fostered partnerships with consumers, providers, advocates and elected officials who are concerned about, and committed to, ensuring a socially responsive and fiscally responsible long-term care system. Ten community-based Long Term Care Coalitions, in partnership with the state, are charged with planning and developing adequate LTC services in their region, including formal and informal support systems and housing options. This statewide network of 14 waiver teams, and ten coalitions representing over 300 individuals and 110 organizations (including the full array of LTC providers), provides the foundation for Vermont's emerging community-based LTC system.

Although Vermont does not have a formal pre-admission screening program for Medicaid beneficiaries, efforts by the LTC Coalitions and the Medicaid Waiver teams have resulted in important changes. The Medicaid Waiver teams actively seek out individuals identified as being at risk for nursing home placement and inform them about the Medicaid Waiver programs and other options. Several LTC Coalitions have worked out agreements with hospitals, whereby a community case manager is included as a member of the discharge planning team. These individuals also meet with hospital patients who are at risk of nursing home placement and inform them of alternative options. Coalitions have also developed preventative screening projects in senior housing sites, recruited and trained paid and volunteer caregivers; successfully recruited new Enhanced Residential Care Waiver providers; expanded adult day services and nutritional services; developed educational materials for both consumers and providers; and expanded case management teams and volunteer networks to assist individuals recently discharged from the nursing home or hospital. The efforts of the 22 state and local partnerships have contributed to a significant decline in nursing facility occupancy in Vermont.



Data Sources:

Vermont has access to a wealth of data in a series of databases, designed to track changes in both functional status and outcomes for individuals across the LTC continuum. The MDS and its subsequent versions have been used in Vermont since 1992. In addition to the MDS database, Vermont has a database, known as the Services, Accounting and Management System (SAMS), used to track demographic, functional and service data for all clients receiving independent living services, including Waiver services, through the Department of Aging and Disabilities. Another database tracks changes in Medicaid Waiver plans of care and is linked to the SAMS database. Medicaid expenditure data is also available from the Electronic Data System (EDS) database. Vermont also measures consumers' satisfaction with both quality of their care and their quality of life through an annual "Consumer Perceptions" survey. Vermont is actively working to improve its ability to create "datamarts", merging elements of the five databases, for planning and utilization review purposes.

For the *One to One* project, MDS data will be used to identify nursing homes residents who fit a profile suggesting either a high potential for community-based services or a high probability for a lengthy institutional stay. Vermont will create and maintain a separate database for the *One to One* project to monitor and analyze progress and to refine its profiling ability.

## Strengths and Weaknesses of Current System

### Strengths

*Collaboration:* As Vermont actively engages in system change initiatives, collaboration is not a buzzword - it has become a necessity. The Coalitions, at varying stages of development throughout the state, provide a forum in which differences of opinion can be safely aired, business approaches to LTC dilemmas debated and collaborative planning for the future take place. LTC providers and consumers have gained a new respect for the work accomplished by each organization. As a result of their close working relationships, the cooperation and collaboration exhibited by these organizations has resulted in more coordinated care for consumers, more efficient use of scarce resources and the development of new or enhanced services.

*Results-Oriented Initiatives:* The focus of Vermont's LTC system is **results-oriented**, in the belief that process issues will be resolved while accomplishing something tangible for consumers. In those coalition areas where...

- a reduction in Medicaid nursing home bed days was the chief performance measure, utilization declined 1.5% in the first year;
- a reduction in light care admissions to nursing homes was a performance measure, light care admissions declined 2.3% from the previous year;
- residential care providers had declined, or committed only minimally, to participate in the Enhanced Residential Care Medicaid Waiver, and coalitions addressed provider recruitment in their Business Plans, participation in the program increased over 80%.

*Experience Using Flexible Funds:* Vermont's long-term care system has several years of experience in effectively utilizing flexible funds to assist consumers. As funds for home and community-based services became available under Act 160, Medicaid Waiver teams and Coalitions were granted flexible funds to be used to provide equipment and services that were not available under the existing Medicaid Waiver programs or other funding sources. A team approach is used to decide priorities for using the funds, with the emphasis on helping Medicaid nursing home residents return to the community or to help prevent or delay institutionalization. Recognizing the importance of this type of funding, the Vermont Legislature increased FY00 funding for the home health agencies' Homemaker program by 52%, with the strong suggestion that the funds be used flexibly and be accessible to individuals in need, regardless of whether they are clients of the home health agency.

*Prioritization Methodology:* Vermont's Medicaid Waiver prioritization system is well developed and has shown clear results during the time it has been in effect. The Waiver teams prioritize applicants for waiver services, and provide a vehicle for problem resolution and service coordination among multiple agencies. The state and Medicaid Waiver teams have tested and modified the procedures to ensure that the most at risk population received Medicaid services.

*Data Resources:* Vermont's data sources are rich and well-developed, allowing us to track changes in functional status and outcomes for LTC consumers across the continuum of care. (See page 12 for details.)

*Home and Community-Based System Improvements:* A consumer-centered and consumer-focused LTC system has long been Vermont's goal. Recently, in collaboration with consumers, advocates and long-term care services providers, Vermont added both consumer-directed and surrogate-directed options to its Home and Community-Based Medicaid Waiver program.

In SFY99, 12.5% of waiver personal care and 32.6% of respite care were provided through consumer-directed or surrogate-directed service options. An intensive, statewide case management training and certification program is also well underway. Training is provided to all area agency on aging case managers and home health agency Medicaid Waiver case managers. Increased emphasis has also been placed on quality improvement in the home and community-based programs through site visits, consumer and staff interviews and consumer satisfaction surveys.

*Housing:* The residential care home industry in Vermont is a critical component of the long-term care continuum, particularly for individuals who can no longer live independently. The chronic under funding of the industry has resulted in homes closing and the deferral of necessary maintenance and repairs. In FY00, Vermont, in collaboration with the Social Security Administration, will institute a new state plan service, Assitive Community Care Service (ACCS), which will provide an increase of up to 34% in residential care home reimbursement for SSI recipients.

The Department of Aging and Disabilities has worked for several years with a group of providers and housing experts to craft model regulations for the development of Assisted Living Residences (ALRs) in Vermont. Regulations are in the final stages of development and several projects have already started through Vermont's lengthy permitting process.

*Core Capacity Research:* In the past, lack of quantitative information concerning the regional supply of community-based services necessary to develop and create a consumer driven long-term care system, and the resources necessary to develop and sustain that system, have hampered the advocacy efforts of the Agency of Human Services. By November, 1999, the results of an intensive study to determine the adequate delivery capacity for each area of the state will be available. This study will provide critical information for planners, policy makers and funding entities and will provide the basis for determining funding decisions and much needed infrastructure changes.

*Nursing Home Quality Improvement Initiatives:* In the past year, Vermont has placed greater efforts on working collaboratively with the nursing home industry to improve the quality of care and quality of life for nursing home residents, regardless of payer source. In consultation with the nursing home industry and the Vermont Program for Quality in Health Care (VPQHC), a methodology was developed using survey results, cost efficiency data and consumer satisfaction survey data. This methodology will be used each year to present "Quality Awards" to five outstanding facilities. In addition, "Enhanced Quality of Life" grants will be given annually to selected nursing homes to fund initiatives to improve the quality of life of their residents. Proposals must show community involvement in the planning and implementation of each project.

Consumer perceptions of quality of care and quality of life are one of the key measurements of a long-term care system. Vermont is one of the first, if not the only state, to have a single consumer satisfaction survey, to be used in all nursing homes. This will be a valuable quality improvement tool for the facilities and, through the Department of Aging and Disabilities' website will provide consumers with comparative information about the state's nursing homes.

### Weaknesses

*Fragmented Funding:* The constraints of categorical, fragmented funding have long been known to the long-term care system. We frequently refer to the "gaps" or to those people who "fall between the cracks" to illustrate the inflexibility of current funding sources. Case managers, advocates and service providers can point to case after case in which they have spent hours and hours searching for that small bit of funding that will pay for a much needed home repair or modification, or the payment that will secure an apartment until the individual is ready to leave the nursing home. Flexible dollars, transferred to the home and community-based system as a result of Act 160, have started to fill some of the gaps; however, current funds are insufficient to serve all of Vermont's "high priority" consumers.

*Housing:* Creating and providing viable housing options with services for individuals in need of long-term care continues to be the greatest challenge. Vermont has an abundance of old housing stock, often in poor repair. Necessary repairs and modifications are usually beyond the means of Medicaid beneficiaries. New apartment-style housing is expensive to construct for a number of reasons: an extensive land-use permitting process, lack of buildable land and the necessary infrastructure; and difficulty in obtaining financing. Vermont's largest city, Burlington, has a rental vacancy rate of 1%, making affordable housing nearly impossible to find.

Other options are still on the drawing board. . Assisted living options for Medicaid beneficiaries are a priority for the state of Vermont. Regulations have been developed, but not yet promulgated. Although some projects are in development, they are primarily for middle and upper income consumers. Additionally, in collaboration with two LTC coalitions, Vermont is studying the feasibility of implementing adult family care as a Medicaid Waiver service. Small, close-knit family settings could provide a comforting option for some consumers.

At this point, aging and disabled consumers have not been recognized as a priority population for the housing development community in Vermont. That situation can and must be rectified.

*Cultural Issues in Health Care:* The different cultures in the long-term care continuum have led us to confront ethical issues concerning perceptions of independence and "safety" in the community that were not relevant even a few years ago. Innovative medical equipment, new pharmaceuticals and assistive technology have all made it possible to provide a broad range of care in non-institutional settings. Based on their culture and training, LTC service providers have different comfort levels with what they consider to be "safe" living options in the community. Vermont has spent a great deal of time working with advocates, consumers, families, Public Guardians, and service providers to create Informed Consent/Negotiated Risk policies, which provide a means for concerned parties to work through the differences in their approaches to these issues. In *One to One*, Vermont must build on this foundation to ensure the broadest exercise of consumers' informed decision-making.

*Mental Health Services:* Depression, anxiety and other mental health issues often play a critical role in an individual's ability to succeed in the community; however, mental health services are not readily available to the elderly and disabled population. Access to mental health counseling for the elderly has been identified as a priority by the Community LTC Coalitions, the Department of Social Welfare (Medicaid) and the Department of Aging and Disabilities. The Department of Developmental and Mental Health Services has agreed to work diligently with these other entities to increase the availability of and access to these critical services.

### Expected Results and Systems Reforms Anticipated

During the project timeframe, 190 Medicaid nursing home residents, or 8.28% of the state's Medicaid nursing home population, will transition to a community based setting. This includes approximately 90 individuals identified as having High Potential for Community Placement (HPCP) who, according to FY98 statistics, might have left the nursing home at some point using currently existing supports, but will leave earlier due to *One to One*. It also includes approximately 100 individuals who would remain in a nursing home without *One to One* support. Forty individuals, meeting the HPCP profile and using *One to One* resources, will transition to a community setting, thereby increasing the state's average annual performance by 45% for people moving from nursing homes to Medicaid Waiver services. Additionally, 60 of these individuals, or 2.6% of the nursing home Medicaid population, will meet the profile for Potential Long Term Residents (PLT). These individuals appear to face a long-term Medicaid stay based on RUGs data. The project will also serve any other individual who expresses an interest in leaving a facility.

Project savings, estimated at \$1.4 million, will be reinvested in *One to One* activities subsequent to the expiration of the grant period. The project will expand statewide in SFY2000, tailored to Vermont's experience in providing community-based care to both nursing home residents with a high potential for community placement and those who historically have become long-term residents.

*Housing Initiatives:* New partnerships will be formed with federal and Vermont-based housing developers and funding agencies to bring the housing needs of the elderly and disabled to the forefront and to seek innovative methods of developing housing alternatives for this population. A fourth reimbursement tier will be added to the Enhanced Residential Care Waiver, designed to encourage participating residential care providers to accept Medicaid beneficiaries who are nursing home residents.

Additionally, state government, within its collaborative partnerships, will implement a variety of additional housing and services options for Medicaid beneficiaries.

*Case Management Standards Improved:* Improved standards and protocols for staff providing intensive case management to *One to One* consumers will be developed and replicated throughout the state. Communication protocols between providers will be improved and standardized. Case managers will receive technical assistance in the development and utilization of integrated case management teams, which will benefit the consumer. Case managers will develop greater skills and expertise in identifying and assisting consumers to achieve their goal of returning to the community. This expertise will be used to enhance the existing statewide case management training and certification program.

*Identification Methodology Refined:* With *One to One* support, Vermont will develop the capability to accurately identify, within two months of nursing home admission, those Medicaid beneficiaries who could potentially succeed in the community-based setting they prefer. The project will help define the content and optimum timing for intervention for both HPCP and PLT residents.

*Partnerships Strengthened:* Existing partnerships among local long-term care services provider organizations will be strengthened as they collaborate with case managers to assist consumers to return to the community. Housing agencies will become active members of their Community LTC Coalitions, adding their voices and expertise to planning LTC services in their communities.

*Waivers:* Based on project results, Vermont will either initiate a new waiver targeted specifically to Medicaid beneficiaries who have been in a nursing home for at least four months and wish to return to the community and/or change existing waiver service definitions and limitations.

### **Proposed Project**

With the help of HCFA's "Nursing Home Transitions Initiative," the state will identify nursing home residents meeting HPCP and PLT profiles and refer them to regional Utilization Review/Level of Care staff. A registered nurse from the local certified home health agency will review the related case files and refer identified individuals for intensive case management services.

Project funding will then support case managers as they develop *One to One* relationships with nursing home residents. If the consumer wishes to leave the nursing home, a case manager will perform a formal assessment and, in collaboration with the consumer, his/her family and caregivers, identify the services and resources necessary for the consumer to safely return to the community. This individually tailored service plan may include existing services as well as individualized "wraparound" services. (See pages 25-26 for list of services.) The case manager will obtain the services and other necessary resources, assist in the community transition and closely monitor the health and well-being of the consumer. Additional education will be provided to prescribing physicians, family members, caregivers and/or service providers whose wishes, perceptions or preferences may differ from that of the consumer.

### **Target Population:**

The target population is described in two ways – by consumer characteristics and by the area of the state in which his/her nursing home is located. Using screening and identification tools recently developed within the Department of Aging and Disabilities, Vermont's "*One to One*" Project will target individuals who:

- based on their MDS profile, appear to have a high potential to return successfully to the community;
- based on their RUGs class and other variables, appear to face the prospect of a long-term Medicaid stay; or
- express an interest in leaving the facility.

In the first phase of project operations, individuals who are identified from the MDS database as having a "High Potential for Community Placement," (HPCP) based on their RUGs Class, source of payment, continence, cognition and preference for community-based services will be placed on a roster. (The technical study used as a basis for this constellation of variables is included in Appendix A. Significantly, because many of the nursing home residents who meet this profile are short-term stayers, the Activities of Daily Living do not play an important role in determining probability of re-entry into the community.) During the first quarter of 1999, 11% of the total nursing home population (N=382) met the HPCP profile. While length of stay varied, 75% of the HCPC group had a length of stay less than 100 days. Medicaid was the primary payor for 83.5% of the HPCP group. During the *One to One* project, the baseline performance measure will increase by 45% from the FY98 level of 90 residents to a level of 130 residents. An estimated 48.9% of nursing home residents meeting the HPCP profile with a nursing home stay of less than one year will make the *One to One* transition back to the community. While in the past, only 40% of nursing homes residents transitioning to the community were Medicaid beneficiaries, *One to One* will dramatically increase this to 59%.

**LENGTH OF STAY: HPCP**

<b>CONTINENT:</b>	<b>&lt;100 Days</b>	<b>100 Days- 1 Year</b>	<b>1-2 Years</b>	<b>2+ Years</b>	<b>TOTAL</b>
<b>Medicare</b>	<b>32</b>	<b>12</b>	<b>6</b>	<b>3</b>	<b>53</b>
<b>Medicaid</b>	<b>162</b>	<b>43</b>	<b>23</b>	<b>73</b>	<b>301</b>
<b>Dual</b>	<b>4</b>	<b>1</b>	<b>2</b>	<b>1</b>	<b>8</b>
<b>INCONTINENT:</b>					
<b>Medicare</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>2</b>
<b>Medicaid</b>	<b>7</b>	<b>4</b>	<b>3</b>	<b>4</b>	<b>18</b>
<b>TOTAL</b>	<b>206</b>	<b>61</b>	<b>34</b>	<b>81</b>	<b>382</b>

For details on this work, see [Attachment C](#).

The second phase of the project will build on initial successes. Operating in the same geographic areas, the project will begin to target those residents in the following RUGs classes: "Potential Long Term Nursing Home Residents" (PLT) are currently identified using the RUGs groupings as "Special Care "(ADL 17-18), "Clinically Complex, Depressed" (ADL 11-18), "Cognitively Impaired" (ADL 6-10), and "Reduced Physical Functioning" (ADL 4-5 or ADL 11-18).

As a group, these individuals:

- represent a high proportion of Medicaid beneficiaries upon admission;
- demonstrate a relatively low turnover rate; and
- have relatively long lengths of stay in a nursing home.

In the first quarter of 1999, this group, which excludes any member of the HCPC group, represented 1637 individuals, or 47.3% of Vermont’s nursing home population. For 93.5% of this group, Medicaid was the primary payer.

**LENGTH OF STAY: PLT**

<b>PAYOR</b>	<b>&lt;100 Days</b>	<b>100 Days – 1 Year</b>	<b>1-2 Years</b>	<b>2 Years</b>	<b>2+ Years</b>	<b>TOTAL</b>
<b>Medicare</b>	<b>52</b>	<b>15</b>	<b>2</b>	<b>2</b>	<b>10</b>	<b>81</b>
<b>Medicaid</b>	<b>58</b>	<b>242</b>	<b>282</b>	<b>227</b>	<b>722</b>	<b>1531</b>
<b>Dual</b>	<b>3</b>	<b>6</b>	<b>4</b>	<b>3</b>	<b>9</b>	<b>25</b>
<b>TOTAL</b>	<b>113</b>	<b>263</b>	<b>288</b>	<b>232</b>	<b>741</b>	<b>1637</b>

Of particular note is the length of stay for the PLT group; over half (59.4%) have lived in a nursing home for more than two years. Project staff will keep careful track of which sub-group has the most success in safely returning to the community. While our current knowledge would suggest that early intervention will yield a greater probability of successful transition, *One to One* will allow Vermont the opportunity to develop interventions for those individuals with longer lengths of stay. This information, and case managers’ conclusions about needed services, will be used to assess the need for new and/or different waiver services. Regardless of current length of stay, the PLT group has the potential to generate significant savings in Medicaid -- dollars which will then be shifted to community-based services. *One to One* project estimates are that 3% (N=40) of the potential long-term residents will successfully transition to community settings.

In a final phase, fueled by project-generated savings, Vermont plans to expand *One to One* statewide. This expansion will be based on documented savings, demonstrated success by case managers, and an assessment of additional LTC coalitions’ ability to achieve project objectives.

The selection of initial implementation sites will be based on the following criteria:

- Degree of commitment to this project and to the goals of Act 160;
- Number and rate of area nursing home residents meeting the HPCP profile for moving back to the community;
- Number and rate of area nursing home residents meeting the PLT profile;
- Number and rate of area nursing home residents expressing an interest in moving to a community setting;
- Demonstrated ability of local case management;
- Demonstrated cooperation and collaboration between the regional LTC system and local housing agencies;
- Demonstrated cooperation and collaboration between the regional LTC system and local nursing facilities;
- Demonstrated ability of existing service providers to serve people with high levels of need;
- Demonstrated ability of existing service providers to assist people in successful transition from a nursing home to a community-based setting;
- Degree of nursing home participation and collaboration in the regional long term care coalition; and
- Demonstrated ability to "pool" flexible funds, with *One to One* grant money, including local, Act 160, Homemaker, and Older Americans Act Special Services and Title III D funds, to supply "wraparound" services.

Preliminary data on initial selection criteria demonstrate significant differences in the potential *One to One* sites.

**SELECTION CRITERIA**

<b>COALITION</b>	Number of NH residents meeting HPCP: Medicaid, Continent	Number of NH residents meeting HPCP: Medicaid, Incontinent	Number of NH residents meeting PLT: Medicaid	Number of NH residents meeting PLT: Medicare	Success in NH to CBS Transition: NH Admits to Waiver Per 1,000 Capita 65+ (6/99)
Addison	11	3	69	0	.54
Bennington	32	0	162	8	1.28
Champlain	59	4	225	15	.69
CVHHSN	34	1	175	4	1.30
Franklin/GI	11	0	105	5	1.66
Lamoille	14	1	64	4	2.06
NEK	31	0	157	6	2.06*
Rutland	42	2	195	9	.76
Washington	38	4	199	14	2.85
Windham	20	3	148	11	.87
State	362**	18	1556***	81***	1.33

\* Excludes Essex County

\*\* Includes 2 currently Medicare Incontinent and 53 currently Medicare Incontinent

\*\*\* Includes 62 residents not assigned to any Coalition

## Potential Data Sources

Vermont has developed rich data sources, which will be valuable in determining the target population for this initiative, in tracking their health and well-being once they return to the community and in determining the savings generated by successful transitions to the community. Consumers' perceptions of their quality of care and quality of life also are critical components of our data set.

Increasingly, Vermont will use the concept of "data marts" to effectively manipulate disparate data elements. (See pages 12-13 for detailed description of data sources.)

## Services to be Made Available:

Case managers and waiver teams will offer interested individuals priority access to core long-term care services:

- Home-Based Medicaid Waiver (including consumer-directed, surrogate-directed, and agency-managed service options): Providing case management, personal care, adult day, respite care, and assistive devices and modifications.
- Enhanced Residential Care Medicaid Waiver services: case management and Enhanced Residential Care services.
- Homemaker services.

Other community-based services, such as home-delivered meals, advocacy, nutrition counseling and Senior Companion and informal support services from volunteers and other local Community Cares organizations will also be available to Medicaid beneficiaries transitioning to the community. Two of the potential *One to One* sites have also made provisions for access to special mental health services for the elderly.

In addition, case managers will offer individuals new services through this project:

- *"Wraparound" Funding*: Grant funds will be used for one-time or transition costs to assist people in moving to the community. Potential uses include, but are not limited to, housing, rent or utility deposits; moving expenses, household necessities, home modifications and repairs and equipment purchases.
- *Individualized Service Rates*: Reimbursement under the Enhanced Residential Care Medicaid Waiver will be changed to include a new tier of reimbursement for individuals who have been residents of a nursing home for four months or more. This new reimbursement tier will reimburse residential care providers at a higher rate, encouraging them to accept and adequately serve applicants with higher levels of need from the nursing home setting.
- *Housing*: Partnerships will be developed with federal, state and local housing organizations to facilitate smooth transitions to the community. In some potential areas, housing providers already have targeted individuals leaving the nursing home as priority customers for their units. An expansion of this policy will be pursued throughout the state. Case managers will coordinate with LTC providers and volunteer organizations to maximize the services delivered to individuals moving to the community. Innovative ways to provide services to residents in senior congregate housing settings will be pursued. In collaboration with the LTC Coalitions, family care, home sharing and other alternative housing arrangements will be researched and piloted in selected areas of the state.

Vermont is also actively pursuing a Group-Directed Attendant Care Program for physically disabled individuals.

This program would follow the successful model first implemented at University of California, Berkley.

#### Communication/Access Plan:

Preference for project participation will be given to those coalitions in areas where nursing homes will be fully engaged in the *One to One* project.

Communication and access to the *One to One* project will occur as follows. Relying on methodology developed by the Department of Aging and Disabilities, which uses MDS data, nursing home residents fitting first the HCPC and later the PLT profiles will be provided to the local Utilization Review/Level of Care (UR/LOC) nursing staff from the area's certified home health agency. UR/LOC staff will also review case records at the area nursing homes to determine which individuals have expressed a preference for return to the community. UR/LOC staff will make referrals to the *One to One* case managers. The most critical communication will occur between case managers and nursing home residents. The project acknowledges the importance of this relationship in its name, *One to One*, and will rely on selected individual case managers who have a professional reputation for excellent interpersonal skills, innovation, reliability, and thorough knowledge of existing and potential formal and informal resources. The *One to One* case managers will assess the needs of the Medicaid beneficiary and assist with the transition to the community.

The second form of communication and access to the project will involve the use of informational seminars, posters and brochures to raise residents' and family members' awareness of the project. The Department of Aging and Disabilities also has a well-developed website that contains consumer-oriented information about nursing homes and other long-term care services (<http://www.dad.state.vt.us>). Information about the *One to One* project will be disseminated using all the above mentioned media.

Third, in addition to communication with residents, family members and caregivers, project staff will establish productive relationships with facility staff and administrators, and family physicians who may influence the array of choices the consumer thinks viable, and with family members who often play a role in decision making for/with the consumer. The Ombudsman program whose members can help smooth the way for a transition from the nursing home to the community, will also participate.

#### Removal of Barriers

Three major barriers stand in the way of Vermont's nursing home residents moving to less restrictive settings. The first barrier is the fragmentation of funding and the limited flexibility in funding streams. Case managers throughout the state can point to case after case where the categorical and inflexible nature of funding streams often have created nearly insurmountable barriers to helping individuals return to the community. Although Act 160 has provided some flexible funds for use by Medicaid Waiver teams and the Community LTC Coalitions, it has not been sufficient. Approximately four out of five of those individuals who have been identified as HPCP remain in nursing homes.

The second barrier is the lack of appropriate and affordable housing. Nursing home residents often have either given up their place of residence or found that it no longer meets their needs due to a change in their functional and/or cognitive status. Many of Vermont's private residences and rental housing stock are old and needs costly repairs. Newer housing is scarce and expensive, usually far beyond the means of Medicaid beneficiaries. Until now, Vermont's housing focus has been on children and families. That focus must be expanded to include the elderly and individuals with disabilities. Projected demographics alone should drive that change; however, Vermont's consumer-centered long-term care system will also provide the impetus for new partnerships and initiatives with the housing industry.

Long standing cultural perceptions among certain parts of the long-term care system have created a third barrier. Vermont's past experience, in the both Public Guardian program and in the Medicaid Waiver program, has exposed a culture within the long term care system which is often paternalistic and protectionist. The development of Medicaid Waiver Teams and Informed Consent/Negotiated Risk policies have provided a vehicle for consumers, families, caregivers and case managers to address the challenges of providing both independence and safety. This project will bring increased focus to these challenges, and will increase the competence and comfort level of local staff in ensuring both independence and safety as they support the expressed wishes of consumers to live in the settings they prefer.

#### Waivers:

Based on project findings, Vermont will either add a new waiver, targeted to Medicaid beneficiaries who would like to transition to the community, or amend the current home and community-based waiver to include or change services designed to support that transition. Our current Medicaid Waiver programs already provide priority access to services for people who transition from nursing homes to other community settings. Rather than developing separate waivers, Vermont has chosen to increase the variety of services offered under its Home-Based Waiver. For example, within the last year we have added consumer-directed and surrogate-directed options to this Waiver. We plan to add a fourth reimbursement tier to our Enhanced Residential Care Waiver, which would reimburse providers at a higher rate for individuals who have been residents of a nursing home.

Initial development is also underway to add the following services to the Home-Based Waiver: Senior Companion Services; home-delivered meals; nutrition counseling by a registered dietician; supportive services in congregate housing; and other housing and services options necessary to meet market preferences.

#### Partnerships:

Vermont has always placed its partnerships with consumers above all others and will continue to do so. In 1992, Vermont began the development of a "Community-Assisted Independent Living System" with the help of consumers, advocates and providers. The paramount goal of all parties involved in that initiative was to develop a consumer-centered and consumer-responsive LTC system.

The Agency of Human Services, through the Department of Aging and Disabilities has continued that effort and is now actively engaged in partnerships with the community-based LTC coalitions. These ten coalitions, covering the entire state, represent consumers, the Vermont Center for Independent Living, area agencies on aging, advocates, home health agencies, AARP, housing authorities, nursing homes, transportation providers, adult day providers, residential care home providers, hospitals, mental health agencies, volunteer organizations, elected officials and the Alzheimer's Association. In a statewide Coalition Conference in June, 1999, the Department of Social Welfare, which houses the Medicaid offices, and the Department of Aging and Disabilities jointly announced their intent to create a Vermont where elders and people with disabilities live with independence and dignity in settings they prefer. The Department of Developmental and Mental Health has also agreed to join that partnership to ensure access to mental health services for the elderly and disabled populations.

Other agencies that already have agreed to participate in the planning and implementation of the *One by One* housing initiatives include the Vermont State Housing Authority, Vermont Housing Finance Agency, the Vermont Department of Housing and Community Affairs, local housing authorities, the Ombudsman program, the Vermont Center for Independent Living, the Medicaid Advisory Board and the Advisory Board to the Department of Aging and Disabilities. This planning and implementation group will also include the regional office of the Department of Housing and Urban Development, the Vermont Housing Conservation Board, and the Vermont Coalition for Disability Rights.

#### Monitoring Plan:

Vermont recognizes the need to pay special attention to the well-being of the *One to One* transition population. Individuals who have been in an institution for some time might need to relearn some of the skills necessary to live independently. In addition, they will have ongoing health and social needs that must be addressed.

*Case Management:* The primary safeguard for people transitioning from nursing homes to community settings is effective case management. Currently, case managers monitor all Medicaid Waiver participants on at least a monthly basis; many participants are seen more frequently. For the intensive case management needed for *One to One* consumers, case managers will collaborate with consumers, family members, and service providers in developing appropriate service plans and closely monitor the implementation of those plans. Case managers will frequently assess the consumer's situation and, in consultation with the consumer and his/her family, with monitor their situations and be in frequent contact with the individuals, caregivers, family members and service providers and adjust the services needed through an individualized plan of care, responding to changes in need and circumstances. Protocols will be developed to ensure that consumers under the *One by One* program are carefully monitored.

- *Consumer Choice:* As an important part of the project, case managers will develop a *One to One* relationship to build trust and respect with Medicaid beneficiaries prior to asking if they would like to move to a community setting. As noted earlier, Vermont will pay increased attention to ensuring that acceptable risk negotiation strategies are in place statewide.
- *Individualized Services:* Consumers will continue to be active participants in the development of their individualized service plans. Plans of care are individualized to reflect differences in consumers' cognitive status, functional independence, lifestyle, informal supports, and other formal services. The department will continue to measure consumers' perceived degree of control in their planning services.

- *Case Management Teams*: Case managers will continue to work as part of a local Medicaid Waiver Team, which provides a vehicle for local community members to discuss and address individual service and safety issues. In *One to One*, they will further develop relationships with UR/LOC teams.
- *Informed Consent/Negotiated Risk*: This will be critical to the success of the *One to One* project, and is further explained on page 17.
- *Department of Aging and Disabilities staff oversight*: Staff from the Department's Division of Advocacy and Independent Living (DAIL) will continue to attend Medicaid Waiver Team meetings on an intermittent basis and perform utilization review of 100% of Medicaid Waiver plans of care.

The Department's Division of Licensing and Protection, the state's licensing and certification division, approves and monitors all residential placements under the Enhanced Residential Care Medicaid Waiver. Case Managers from the area agencies on aging or a certified home health agencies will continue to monitor the well being of their clients under this Waiver program.

The Department's Division of Planning and Analysis routinely monitors, analyzes and evaluates LTC activity within the state, and will pay close attention to the *One to One* project to measure its impact on the state's LTC system.

#### Housing:

As noted earlier in this proposal, developing adequate housing options for elderly and disabled individuals, and for the transition population in particular, presents many challenges. The first step in addressing this issue will be to a mandate for all housing organizations in Vermont. Housing providers will be urged to examine their policies and procedures to ensure that the *One to One* population is given a priority status for housing units. The Agency of Human Services and housing providers must work together to solve the supply issue for both the physical plant and the social support services needed for this population. Key Vermont housing partners (see page 31) along with the Ombudsman program, the Vermont Center for Independent Living, the Medicaid Advisory Board and the Advisory Board to the Department of Aging and Disabilities have agreed to work together to find solutions to this issue. We will also pursue the participation of the Vermont Housing Conservation Board, the regional office of the Department of Housing and Urban Development and the Vermont Coalition for Disability Rights in these efforts.

In order to enhance and maintain the quality of life for elders and individuals with disabilities, the housing coalition will address the key issues --affordability, accessibility and integration into the community.

The coalition of housing and advocacy organizations will address regulatory and program requirements that might be modified, local and state permitting procedures that might be amended, innovative financing mechanisms, tax incentives and other avenues that will create an environment in which housing elderly and disabled individuals is an attractive venture, ultimately benefiting the consumer.

**MILESTONES:**

<b><u>MILESTONE:</u></b>	<b><u>Q1</u></b>	<b><u>Q2</u></b>	<b><u>Q3</u></b>	<b><u>Q4</u></b>	<b><u>Q5</u></b>	<b><u>Q6</u></b>
<b>Notice of Grant Award Received</b>	X					
<b>RFP Issued and Project Sites Selected</b>	X					
<b>Case Managers Hired</b>	X					
<b>Standards and Protocols Developed for Use by <i>One to One</i> Case Managers and UR/LOC Staff</b>						
<b>Promotional Materials Printed/Distributed</b>	X					
<b>All Reporting Formats and Database Developed</b>	X					
<b>All Information Flow Protocols Developed</b>	X					
<b>HPCP and PLT Residents Identified</b>	X					
<b>UR/LOC Review Begins with Referrals to One by One Case Managers</b>	X					
<b>Project Oversight Committee Meets: Clarify Functions and Establish Regional Allocations</b>	X					
<b>Begin Integrated Case Management Technical Assistance</b>		X		X		X
<b>Create New Waiver or Add Services to Existing Aged and Disabled Waiver Based on Project Results</b>				X	X	
<b>4<sup>th</sup> Reimbursement Tier Added to Enhanced Residential Care Medicaid Waiver</b>		X				
<b>Analyze and Refine Resident Profiling Based on Project Data</b>			X	X	X	
<b>Determine Project Savings and Amount Available to Re-invest in Community-Based Services</b>				X		
<b>Housing Coalition Meets. Plans to Address Housing Needs Are Developed</b>	X	X	X			
<b>Interim Project Report Due</b>			X			

<b>Final Project Report Due</b>					<b>X</b>	
<b>FY01 Budget Developed</b>	<b>X</b>					
<b>FY02 Budget Developed</b>					<b>X</b>	
<b>Vermont Legislature in Session</b>		<b>X</b>	<b>X</b>			<b>X</b>
<b>State Fiscal Year Begins</b>				<b>X</b>		

**PROJECT ORGANIZATION AND STAFFING:**

The Project Director will be Patrick Flood, Director of the Department of Aging and Disabilities’ Division of Advocacy and Independent Living. Assistant Project Director will be Bard Hill, Chief of Home and Community-Based Services, Department of Aging and Disabilities. Research Analyst will be Joseph Murray, of the Department of Aging and Disabilities’ Planning and Analysis staff. Each participating coalition will also delegate oversight responsibilities to an existing committee or establish such a committee within the coalition area. (See Attachment D.) A statewide Project Oversight Committee will be charged with providing policy direction, developing broad agreements pertaining to regional funding allocations and providing program oversight. Membership will consist of key members from participating LTC coalitions, including nursing home administrators.

The Commissioners of the Departments of Social Welfare and of Aging and Disabilities, or their designees, will also sit on the Oversight Committee. (For resumes, see Attachment E.)

**ENDORSEMENTS:**

The proposed project has been greeted with interest and enthusiasm. Formal letters of endorsement and support have already been received from the Governor of the State of Vermont, the Executive Director of the Vermont Housing Finance Agency, the Executive Director of the Vermont State Housing Authority, the Executive Director of the Montpelier Housing Authority, the Executive Director of the Northeastern Vermont Area Agency on Aging, the Vermont Center for Independent Living, the Administrators of Woodridge Nursing Home and Berlin Health and Rehabilitation Center, the Connecticut Valley LTC Coalition, the Rutland County LTC Coalition, the Lamoille Valley Coalition, the Bennington County Coalition and the State Ombudsman. Copies of letters of support are included as Attachment A.

**PROJECT BUDGET:**

HCFA’s well-timed initiative will fuel Vermont’s second generation efforts to support people living with independence and dignity in the settings they prefer. HCFA’s grant funds are devoted to two key features: wraparound funding for transition services and funds for specialized case management. Vermont’s Governor has pledged to reinvest any project savings back into the program, thereby allowing statewide expansion. The individual benefit to Medicaid recipients moving from nursing homes to community based settings will be significantly enhanced by broad changes in the infrastructure.

**HCFA GRANT: NURSING HOME TRANSITIONS  
INITIATIVE**

**PROPOSED BUDGET: July 1999**

	<u>FEDERAL</u>	<u>NON-FEDERAL</u>	<u>TOTAL</u>
<b>PERSONNEL</b>			
Commissioner: DA&D			
.05 FTE		\$3,500	\$3,500
Commissioner: DSW			
.05 FTE		\$3,500	\$3,500
State Medicaid Director			
.10 FTE		\$6,000	\$6,000
State Project Director			
.25 FTE		\$12,500	\$12,500
Regional Project Directors			
3 @ .10 FTE		\$12,500	\$12,500
IS Developer			
.15 FTE		\$6,000	\$6,000
Data Analyst			
.50 FTE		\$21,000	\$21,000
<b>Sub-Total Personnel</b>	\$0	\$65,000	\$65,000
Fringe Benefits @30%	\$0	\$19,500	\$19,500
<b>TOTAL Personnel</b>	\$0	\$84,500	\$84,500
Travel	\$10,000	\$5,000	\$15,000
Equipment			
Supplies	\$10,000	\$5,000	\$15,000
Contractual		\$2,500	\$2,500
Construction			

Other:			
"Flex Funding"	\$285,000		\$285,000
Waiver Slots		\$1,509,750	\$1,509,750
Integrated Case Management	\$125,000		
Utilization Review	\$50,000		
Total Direct Charges	\$480,000	\$1,691,250	\$2,171,250
Indirect Charges @4%	\$19,200		\$19,200
<b>TOTALS</b>	<b>\$499,200</b>	<b>\$1,691,250</b>	<b>\$2,190,450</b>

The Department requests \$499,200 in HCFA project funds and will supply \$1,691,250 in matching funds. The total budget of \$2,190,450 represents a 22/78 match of HCFA grant funds to local match. All Vermont personnel are donated to the project, as are a portion of Travel, Supplies and Contractual. The budget does not include the additional resources that participating Coalitions will bring to the project. The match to HCFA's "Flex Funding" has not been included in the budget at this date, but will appear once project sites are selected and match is contributed to the regional "Flex Pool."

The amount of "Flex Funding" was estimated in two different ways. For the small number (7) of people who would receive only "Flex Funded" services, the estimated cost is projected to be \$18,000/consumer. For consumers receiving Waiver services, the grant-funded wraparound is calculated using \$3,700/consumer. Annual waiver cost for FY00 are projected at \$16,500/slot due to the anticipated higher acuity needs of consumers and to FY00 provider rate increases. The \$125,000 for integrated case management will purchase all necessary *One to One* case management services for 3 or 4 areas of the state at \$31,250 –\$41,666/area. Utilization Review funds will support activities by regional UR/LOC teams for project -related activities. The state has a standard Indirect charge of 4% on small grants.

Project related savings were calculated by assuming that each day a One to One consumer received services from the project, they would otherwise be in a nursing home. Avoided costs are based on an average annual nursing home cost of\$38,643. Savings assume that all 190 participants have transitioned to the community for an average 6 months during the project.

### Biographical Sketch

<p><b>NAME</b> PATRICK FLOOD</p>	<p><b>TITLE</b> DIRECTOR, DIVISION OF ADVOCACY AND INDEPENDENT LIVING</p>
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**ROLE IN PROPOSED PROJECT**

Project Director

**EDUCATION** (Begin with Baccalaureate training and include post-doctoral training)

INSTITUTION AND LOCATION	DEGREE(s)	YEAR CONFERRED	PROFESSIONAL FIELD
HARVARD UNIVERSITY	BA	1973	HUMAN SERVICES EXECUTIVE
PONDVILLE HOSPITAL OF PRACTICAL NURSING	L.P.N. LICENSE	1977	

**RESEARCH AND/PROFESSIONAL EXPERIENCE**

1994-1999 – Director, Division of Advocacy and Independent Living, Department of Aging and Disabilities, State of Vermont. Division responsible for home and community based services to elders and adults with disabilities

1989-1994 – Director, Division of Licensing and Protection, Department of Aging and Disabilities, State of Vermont. Responsible for licensing and certification of health care providers including nursing homes, home health agencies, board and care facilities and a variety of other Medicare providers. The Division also included the Adult Protective Services office (abuse investigations) and the Office of Public Guardian.

1988-1989 – Director, Office of Public Guardian. Developed the new Office of Public Guardian, providing guardianship services for persons over 60.

1984-1988 – State Long Term Care Ombudsman

1983-1984 – Senior Advocate, Council on Aging, Barre, VT. Acted as caseworker for persons over 60 living at home, arranging for and coordinating services.

1977-1983 – Licensed Practical Nurse in a wide variety of health care settings.

### Biographical Sketch

NAME	TITLE
Bard Hill	Chief of Home and Community Based Services

### ROLE IN PROPOSED PROJECT

Assistant Director

### EDUCATION (Begin with Baccalaureate training and include post-doctoral training)

INSTITUTION AND LOCATION	DEGREE(s)	YEAR CONFERRED	PROFESSIONAL FIELD
University of Vermont; Burlington, Vermont	Bachelor of Arts	1982	Psychology

### RESEARCH AND/PROFESSIONAL EXPERIENCE (Starting with present position, list training and experience relevant to the proposed project.)

- Chief of Home and Community-Based Services, 12/97-present
- Independent Living Programs Administrator, 7/93-12/97
- Children's Mental Health Services Specialist, 7/90-7/93
- Agency Planning Specialist, 9/87-7/90

### Biographical Sketch

<b>NAME</b>	<b>TITLE</b>
Joseph Murray	Research Analyst

#### **ROLE IN PROPOSED PROJECT**

Demographic support, Data analysis, Research, Database Administrator

#### **EDUCATION** (Begin with Baccalaureate training and include post-doctoral training)

INSTITUTION AND LOCATION	DEGREE(s)	YEAR CONFERRED	PROFESSIONAL FIELD
University of Vermont	BS Education	1989	Computer Science, Anthropology, Secondary Education
University of Massachusetts, Boston	MS Public Policy	1996	Public Policy
University of Massachusetts, Boston - Public Policy Ph.D. Program	Ph.D.	Anticipated 1999	Thesis Topic – Community Care as an Alternative to Nursing Homes

#### **RESEARCH AND/PROFESSIONAL EXPERIENCE**

Research Analyst – State of Vermont, Agency of Human Services, Department of Aging and Disabilities, Division of Planning and Analyst

Provide demographics and statistical analysis supporting the Department of Aging and Disabilities, Community-Based Long Term Care Coalitions, and the community.

Researcher – State of Massachusetts, Bunker Hill Community College, Department of Institutional Research

Perform program evaluations, survey research, labor market projections, and economic projections to the college’s executive staff.

Researcher – McCormack Institute, Center for Democracy and Development

Preparation of briefs and research for senior fellows on topics in support of USAID grants for international and governmental development

## **LIST OF ATTACHMENTS**

- **Attachment A** Letters of Endorsement
- **Attachment B** HPCP and PLT Data by LTC Coalition
- **Attachment C** "Nursing Home to Medicaid Waiver in Vermont" study.
- **Attachment D** Project Management Schematic
- **Attachment E** Project Staff Resumes
- **Attachment F** OMB Forms – 424, 424A, Assurances – Non-Construction

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### **ATTACHMENT A**

#### **LETTERS OF ENDORSEMENT**

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### **ATTACHMENT B**

#### **HPCP and PLT DATA by LTC COALITION**

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### **ATTACHMENT C**

#### **NURSING HOMES TO MEDICAID WAIVER IN VERMONT**

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### **ATTACHMENT D**

#### **PROJECT MANAGEMENT SCHEMATIC**

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### **ATTACHMENT E**

#### **PROJECT STAFF RESUMES**

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### **ATTACHMENT F**

#### **OMB FORMS 424, 424A, ASSURANCES – NON-CONSTRUCTION PROGRAM**