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Vermont Choices for Care: Evaluation of Years 1-3

Final Report

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Executive Summary

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

In 2007, an evaluation plan for CFC was developed by CFC's external evaluator, the University of Massachusetts Medical School (UMMS). In this plan, nine desired outcomes were identified, with seven expected to be achieved in the first five years and two to be achieved beyond the demonstration period. By October 2008, UMMS had conducted a number of analyses evaluating CFC policies and procedures as well as progress in meeting its desired outcomes:

- Stakeholder and Consumer Focus Group and Interviews in Year 2 (2008)
- Eligibility Policy Brief (2008)
- Enrollment and Waiting List Policy Brief (2008)
- Quality Management Policy Brief (2009)
- Quantitative Data Report for Demonstration Years 1 and 2 (2009)
- 2008 CFC Outcomes "At-A-Glance" (2009)

These studies were produced from analysis of the following data sources:

- 2006, 2007, and 2008 MACRO International, Inc ("MACRO") Consumer Satisfaction surveys with CFC community-dwelling highest, high and moderate needs participants (and other Vermont long-term care program users and the general Vermont public living in the community) assessing their service satisfaction and quality of life;
- CFC enrollment in 2005-2008 as reported in the Vermont Department of Disabilities, Aging, and Independent Living (DAIL) Social Assistance Management System (SAMS), e.g., participant level of need and authorized service types and settings;
- Clinical assessments (full and intake Independent Living Assessments) completed during 2008 for community-dwelling highest, high, and moderate needs participants active in that year; and
- CFC written policies and procedures related to eligibility, waiting list, and quality management.

Drawing from the findings of these studies, this report summarizes the major developments, challenges, and progress during the first three years of CFC. The report also makes recommendations on steps that CFC could take to help ensure that it meets its desired outcomes.

Major Accomplishments

One of CFC's major objectives was to expand service options for community-dwelling participants. Beginning in year 2, CFC took a step towards this direction with the commencement of enrollment in three new HCBS options: Flexible Choices, a Cash and Counseling-based option; PACE (in Chittenden county and parts of Grand Isle county); and a 24-hour care pilot. In year 3, PACE expanded to a second site (Rutland county and parts of Bennington county). Additionally, policies were finalized in May 2007 to enable spouses of CFC participants to receive payments for providing participant care. These service options enrich the range of options HCBS participants have and constitute a major achievement in increasing long-term care options in the community.

In addition to increasing the different ways participants can receive long-term care services, CFC has also increased the number of individuals it served. In a review of enrollment during the three-year period, we observed an upward trend in total enrollment as well as an upward trend in HCBS, moderate needs, and ERC enrollment. In contrast, nursing facility enrollment *decreased* from the beginning of CFC to mid-FY2008. However, in the latter half of FY2008, ERC and HCBS enrollment leveled off and declined slightly while NF enrollment leveled off and rose slightly. Nursing facility enrollment remained the setting with the largest percent of CFC enrollment across three years.

CFC was consistently a supportive venue for severely disabled low-income adults in Vermont. In each of the three years, the total number of persons who were in the highest needs group outpaced that of persons in either the high or moderate needs groups. The increasing enrollment of the moderate needs group reflects CFC's ability to reach individuals who were excluded from Medicaid long-term care supports under previous Medicaid HCBS waivers. This enrollment trend indicates that CFC is a source of support for wide-ranging levels of needs—both functional and financial.

Progress towards Short-Term Desired Outcomes

By year 3, data were available to examine CFC's progress towards the nine outcomes. In this section, we describe major evaluation findings and make recommendations to DAIL to help make further progress towards the desired outcomes.

Information Dissemination: *Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need.*

- In year 2, stakeholders and participants reported knowing the three major CFC settings but having less knowledge about new CFC options. Furthermore, in years 2 and 3, 79% and 83% of CFC participants respectively who had been hospitalized in the previous 12 months reported receiving information on long-term care upon their hospital discharge (although it was unclear whether these individuals were enrolled in CFC at the time of their hospital

discharge). In response, in year 3, DAIL initiated another major educational event “CFC 101”) in recognition that additional informational training was necessary because options had been developed since CFC inception.

- Year 3 survey data showed that participants with AAA case managers were slightly more likely to report a higher level of satisfaction with choice and control in service planning compared with participants linked with home health.
- Although nursing home resident surveys are assessing quality of care, to date, there is little data assessing nursing facility and ERC participants’ awareness of the full range of CFC options or other aspects of consumer choice and control.

Access: *Participants have timely access to long-term supports in the setting of their choice.*

- In year 2, timely access to CFC services was cited as a concern partly due to the large volume of applications and length of time for financial eligibility determination.
- In response, CFC implemented a “60-day closure” process to help speed the review process for all pending applications. In addition, results from several analyses to quantify the duration of the eligibility determination process suggest that the timeliness of this process improved between year 2 and 3.
- Participants’ ratings regarding timeliness improved between year 1 (84%) and subsequent years (90% in year 2 and 89% in year 3).

Effectiveness: *Participants receive effective HCBS to enable them to live longer in the community.*

- From October 1, 2005 to October 1, 2008, nursing facilities continued to be the most frequent setting for enrollees, followed by HCBS, and ERC settings. However, the enrollment trend over this period was an increase in community settings and a decrease in nursing facilities. Using these points in time, the largest change in enrollment was with participants using community based services. The moderate needs group and HCBS highest/high needs group increased by 1,200 and 450, respectively. ERCs enrollment increased by about 150. Although nursing facility enrollment fluctuated (rose and fell) during year 3, the total net change from year 1 to year 3 was a decrease of 150 (Hill, 2006, 2007, 2008).

Experiences of Care: *Participants have positive experiences with the types, scope, and amount of CFC services.*

- A very high percentage of CFC community-dwelling participants reported high satisfaction with the courtesy of their caregivers in all three years.
- Two analyses were conducted to explore the difference found in satisfaction ratings on experiences of care between the moderate needs group and the highest/high needs group, with the latter reporting more satisfaction. In a study based on interviews with 40 moderate needs participants, interviewees cited lack of flexibility of services, amount of service hours, and worker availability as service barriers (Livingston, 2008).
- The second analysis sought to differentiate several groups within the moderate needs group. Specifically, the moderate needs group is a mix of the following individuals: a) individuals that meet only the CFC moderate level of need; b) individuals who qualify for high level of need but were on the high needs waiting list; and c) individuals who may qualify for high or highest need based on clinical needs but do not meet financial Medicaid long-term care eligibility or choose not to apply for highest or high need services (for patient share or estate recovery-related reasons).

- To explore whether clinical criteria within the moderate needs group were associated with service satisfaction and quality of life, UMMS examined service satisfaction of moderate needs participants who appeared to meet high/highest needs criteria using Independent Living Assessment data. In our 2008 sample, we found that at least 3% of moderate needs participants appeared qualified clinically for highest needs and at least 14% of moderate needs participants appeared qualified clinically for high needs (the 3% is included in the 14%). We did not, however, find any differences in service satisfaction or quality of life between participants served in the moderate needs group who met highest/high clinical criteria and participants served in the moderate needs group who did not meet highest/high clinical criteria. The presence of statistical difference by level of need for several MACRO survey responses, combined with the absence of statistical difference between the subgroups of moderate needs participants, suggests that the moderate needs' access to fewer service hours and choices may be more closely related to their service satisfaction than their differences in clinical characteristics..

Quality of Life: Participants report that their quality of life improves.

- Quantitative and qualitative data consistently pointed to the emphasis of CFC on meeting personal care needs of participants, but less so on meeting other needs that also affect quality of life, e.g., social needs. For instance, some interviewees in 2007 noted the desire for more companion services and non-medical transportation to help participants connect to their community.
- Overall reports of quality of life increased from Year 1 (63%) to Years 2 and 3 (71% and 70% respectively). More specifically, in year 3, 78% of participants reported being satisfied with their ability to move around inside one's home; 67% participants reported being satisfied with how they "spent their free time"; 55% of participants reported satisfied with their "social connections".

Applicants List (Waiting List) Impact: CFC applicants who meet the special circumstances criteria will have equal access to services regardless of the setting of their choice (e.g., nursing home, enhanced residential care, HCBS).

- During the 3-year period, CFC maintained an applicants list 24 months out of 36 months. During this time, the monthly average number of persons on the high needs applicants list during the first three years (50 in the 1st year, 50 in the 2nd year, and 35 in the 3rd year) was far lower than the number of persons on the HCBS waiting list prior to the implementation of CFC (n=241).
- Based on the recommendations of policy reviews by UMMS, CFC implemented the use of a data collection instrument by case managers in Year 2 to document any changes in eligibility and to detect early if or when an applicant became qualified for enrollment.
- The average monthly number of persons on the moderate needs waiting list for homemaker was 169 in year 3, up from 155 in years 2 and 84 in year 1, respectively.

Budget Neutrality: Medicaid's cost of serving CFC participants is equal to or less than would have been spent under the previous Medicaid and HCBS waiver service system.

- CFC actual spending was well below spending projections to CMS during each year. However, spending exceeded state budgeted amounts in year 3.

Progress towards Long-Term Desired Outcomes

Limited data currently exist to illuminate CFC's progress towards long-term desired outcomes: public awareness and health outcomes. The public awareness outcome states that Vermont's general public is aware of the full range of long-term care settings for persons in need of long-term care and have enough information to make decisions regarding long term care while the health outcome states that CFC participants' medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed.

- *Public Awareness:* In year 2, stakeholders and participants reported knowing the three major CFC settings but had less knowledge about new CFC options. Furthermore, in years 2 and 3, 88% and 83% respectively of CFC participants hospitalized during the past 12 months, reported receiving information on long-term care upon their hospital discharge. During year 3, CFC began to explore mechanisms to educate the Vermont public on long-term care options.
- *Health Outcomes:* In their ratings of "Current Health" in 2008, 64.8% of the oldest participants (age 85+) rated their health as either "excellent", "very good", or "good", compared to 50.9% of older participants (ages 65-84) and 38.2% of younger participants (ages 18-64). Statistical differences between each group were significant. In comparison, in 2008, 41.4 percent of Vermont Attendant Services program consumers reported similarly regarding their general health. In contrast, 88.5% of the general Vermont population reported their health as "good" or better, slightly higher than the 85.2% nationwide rate (Centers for Disease Control and Prevention, 2009). On the health rating item ("Health change from 1 year ago"), a larger percentage of younger participants (34.7%) indicated their current health was "much better" or "somewhat better" than one year ago, compared to 25.8% of older participants and 22.5% of oldest participants. In comparison, in 2008, 22.2% of Vermont Attendant Services Program consumers reported an improvement in their health, compared to 23.7% in 2007.

Desired Outcomes by Subgroups for Year 3 (2008)

In 2008, the mid-point of the demonstration period, UMMS was able to conduct more detailed analysis of CFC outcomes by merging the 2008 MACRO Consumer Satisfaction survey responses with participants' independent living assessment and 2008 service authorization data. For a full description of the methodology, see *2008 CFC Outcomes "At-A-Glance"* (2009) on the DAIL website¹. Year 3 endorsement rates by client characteristic subgroups provide a more detailed perspective on CFC satisfaction and quality of life measures at a single point in time, and can provide a baseline from which to compare indicators of progress in future waiver years.

Overall satisfaction and quality of life responses were high. That is, most participants, and in some cases nearly all participants, responded favorably to the MACRO survey items, and generally were as high or higher than in earlier waiver years. Significant differences reported herein should not be interpreted generally in terms of satisfaction vs. dissatisfaction, but rather (in most cases) in terms of differences in levels of satisfaction associated with various client characteristics. Caution should be used when interpreting differences based on client characteristics for the following reasons. These analyses do not reveal the relative importance of one client characteristic over another. Second, because these analyses represent a point in time rather than change over

¹<http://www.ddas.vermont.gov/ddas-publications/publications-idu/publications-idu-documents/outcomes-at-a-glance-august-2009>.

time, they do not speak directly to progress toward CFC goals. Finally, while differences in ratings may reflect something about CFC, they can also reflect something about differences between clients, and we cannot disentangle the source of the differences in this analysis. In brief, we found that:

- Younger participants (18-64) were less likely to report high satisfaction (i.e., rating “excellent” or “good”) with certain aspects of CFC services (“choice and control”, “services timely”, “service fit schedule”) than participants 65 and older. For instance, 83.1% of “younger” participants (18-64 years of age) reported that services were timely compared to 90.2% of “older” (65-85) and 90.8% of “oldest” (85+) participants. Similarly, younger participants were less likely to report high satisfaction with their quality of life than older participants (“quality of life”, “free time”). For example, only 56.5% of younger participants, rated their “quality of life” as good or excellent, compared to 73.5% of older participants and 79.2% of the oldest participants.
- Moderate needs participants reported high satisfaction with CFC services at a lower rate than highest and high needs participants (“services fit schedule”, “quality of services”). For example, 86.1% of moderate needs participants (compared to 97.1% of high needs and 95.5% of highest needs) gave high marks to “services meet needs”. This may be related to the fact that the highest/high needs participants have choices among more CFC settings and service options than the moderate needs participants.
- Participants with AAA case management rated high satisfaction with “choice and control” in planning for services at a higher rate (92.9%) than participants with case management from home health agencies (86.8%).
- Self-directing participants reported high satisfaction with CFC services at a higher rate than participants authorized for agency services, e.g., “service timely” (91.9% for self-directing versus 87.1% for agency-directing), “service meet needs” (96.0% versus 88.5%). In addition, more self-directing participants (97.3%) rated the “Quality of Services” as “good” or “excellent” compared to agency-directed clients (89.7%).

Recommendations

During the 2005-2008 period, DAIL has added long-term care options for community dwellers and continues to work to improve the quality of its services, e.g., timeliness. Across the three years, most community-dwelling participants reported high satisfaction with CFC services. Still, evaluation analyses and policy briefs up to now have raised several areas for DAIL to consider implementing:

- *Information Dissemination:* Ensure that participants in nursing homes and ERCs receive options education on HCBS options, just as participants in HCBS settings do. Equally critical is long-term care clinical coordinator (LTCCC) outreach to key providers (such as hospital and nursing facility discharge planners) on the efficacy of HCBS.
- *Access:* Develop mechanisms that could further improve timeliness of access. One such mechanism is financial presumptive eligibility, although this is subject to CMS approval and available state resources. Furthermore, if Medicaid claims data were to contain accurate service initiation dates in the future, such data could be analyzed for service initiation timeliness in future evaluations. DAIL should consider requiring providers to specify dates of service in claims submission.

- *Effectiveness*: Make self-direction more accessible by conducting greater outreach to other highest/high needs participants and by expanding it to moderate needs participants. Furthermore, CFC efforts can be coordinated with existing grant funding and local resources that finance nursing home diversion activities. For example, combining LTCCC outreach to nursing facility staff and available funding (e.g., rental deposits) to help nursing facility residents transition to more independent settings could help Vermont reduce its nursing home population.
- *Quality of Life*: Encourage case management agencies to develop more partnerships with local organizations that can help CFC participants connect to existing social activities or access more transportation, within existing resources. Such outreach holds CFC case managers accountable to the more holistic case management standards as specified in the DDAS case management standards.
- *High Needs Applicants List and Moderate Needs Waiting List*: Continue to monitor changes in the number of persons on the high needs applicants list and their duration of being on this list. Additionally, as DAIL explores the possibility of making self-direction available to moderate needs participants (as a way to address the moderate needs waiting lists for homemaker services), it would be important to study the impacts of moderate needs self-direction on outcomes such as effectiveness and access.
- *Public Awareness*: Raising Vermonters' awareness of community-based long-term care is an important step to take in tandem with the options education with CFC participants. A public awareness campaign could first be piloted with moderate needs applicants and their family members. The moderate needs group participants may be a logical place because many of them have lower levels of need and do not qualify for Medicaid, thus they, more than the highest/high needs participants, may more closely resemble the general Vermont population with potential or current long-term care needs. Future public awareness campaigns should also engage providers (such as discharge planners in nursing facilities and hospitals).
- *Other Areas for future studies*: While much attention and resources have been on HCBS settings and participants, it is important to pay attention to nursing facility and ERCs in terms of implementation and evaluation. Awareness of long-term care options and quality of life (e.g., "social connections", "go where want or need") of participants in ERCs and nursing facilities (long-term participants) are as important as those of HCBS participants, and therefore evaluation resources should be allocated to study CFC progress towards desired outcomes across settings. Future data collection could include interviews of ERC residents and analysis of MDS data on nursing facility residents. In addition, Medicare and Medicaid claims analysis for the entire CFC population with outcomes related to nursing facility usage and preventable hospitalizations can shed light on the long-term impacts of CFC. Although evaluation work requires resources, it can help identify areas for improvement and thus can help make the best use of available resources for services. Similarly, services that do not target consumers directly, e.g., outreach to providers, play a role in diverting unnecessary nursing facility usage by educating providers who, in turn, would be better-positioned to ensure community options for consumers.

I. Introduction

In October 2005, DAIL 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. A goal of CFC is 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). Individuals meeting highest needs criteria have a choice of any long-term care setting, which in October 2005 encompassed nursing home, 24-hour enhanced residential care (ERC), or consumer-directed, surrogate-directed or agency-based home and community-based services, without being placed on a waiting list pending enrollment. High needs participants also have these choices 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.

To meet federal waiver requirements and assess their own progress, DAIL contracted with the University of Massachusetts Medical School (UMMS) in 2007 to serve as a policy advisor and an independent evaluator for the period of 2007-2010. This report summarizes evaluation findings and policy analysis to date on the outcomes, barriers, and lessons learned from Choices for Care. First, the report describes the evaluation framework that guided evaluation and policy analysis studies that DAIL commissioned. Then, the report summarizes major operational developments during the first three years of CFC. Following this section, we describe evaluation results related to CFC desired outcomes (as described in the evaluation framework section). The first set of results covers the three-year span while the second set of results focuses on the most recent year (year 3 or 2008) data. These results derive from UMMS analyses of qualitative and quantitative data sources (both original and secondary), with some analyses already available on the DAIL website. (These data sources are described below.) Where appropriate, we make recommendations to DAIL as they relate to each desired outcome.

II. Evaluation Framework

To guide all evaluations and policy analysis related to CFC, UMMS and DAIL developed a comprehensive evaluation plan in collaboration with DAIL. The evaluation plan was further refined through input from Vermont stakeholders and national long-term care experts at a roundtable discussion co-hosted by DAIL and UMMS in January 2008. The desired outcomes are as follows, with the short-term desired outcomes expected to be achieved during the

demonstration period and the long-term desired outcomes expected to be achieved after this period:

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

1. **Information Dissemination:** Participants (and their authorized representatives) receive necessary information and support to choose the long-term care setting consistent with the participant's expressed preference and need.
2. **Access:** Participants have timely access to long-term supports in the setting of their choice.
3. **Effectiveness:** Participants receive effective HCBS to enable them to live longer in the community.
4. **Experience of Care:** Participants have positive experiences with the types, scope, and amount of CFC services.
5. **Quality of Life:** Participants report that their quality of life improves.
6. **Applicants List (Waiting List) Impact:** CFC applicants who meet the high needs special circumstances criteria have equal access to services regardless of the setting of their choice (e.g., nursing home, enhanced residential care, HCBS).
7. **Budget Neutrality:** Medicaid's cost of serving CFC participants is equal to or less than would have been spent under the previous Medicaid and HCBS waiver service system.

Long-Term Desired Outcomes (over 5 years):

8. **Public Awareness:** Vermont's general public is aware of the full range of long-term care settings for persons in need of long-term care and have enough information to make decisions regarding long term care.
9. **Health Outcomes:** CFC participants' medical needs are addressed to reduce preventable hospitalizations and their long-term care needs are effectively addressed.

CFC Analysis and Evaluation Products (2005-2008)

Based upon the above evaluation framework, UMMS has produced the following evaluation products:

- Stakeholder and Consumer Focus Group and Interview Report (2008)
- Quantitative Data Report for Demonstration Years 1 and 2 (2009)
- 2008 CFC Outcomes "At-A-Glance" (2009)
- Vermont Choices for Care: Evaluation of Years 1-3 (current report)

UMMS has also produced three policy briefs, analyzing selected CFC policies and procedures with the purpose of assisting Vermont in identifying possible improvements to the operations of CFC. Specifically, DAIL commissioned the following policy briefs:

- Eligibility Policy Brief (2008)
- Enrollment and Waiting List Policy Brief (2008)
- Quality Management Policy Brief (2009)

Data Sources

These evaluation products and policy briefs have drawn upon the following data sources:

- 2006, 2007, and 2008 MACRO surveys with CFC HCBS participants (and other Vermont long-term care program users and the general Vermont public) living in the community regarding service quality, satisfaction, and quality of life;
- CFC enrollment as reported in the DAIL's Social Assistance Management System (SAMS): Data on CFC enrollment by setting (HCBS, ERC, nursing facilities) and service authorization types, (consumer-directed, traditional agency), age, gender, level of need, as well as applicants list information;
- Clinical assessments (full and intake Independent Living Assessments) completed during 2008 for MACRO respondents (surveyed in 2008): Community-dwelling highest and high needs participants are assessed at least once a year using the full Independent Living Assessment. Moderate needs participants may be assessed using either the full or intake (shortened) Independent Living Assessments;
- Interviews/focus groups with participants, family members, providers, and Vermont staff, and advocates between late 2007 and early 2008; and
- CFC written policies and procedures related to eligibility, applicants list, and quality management.

Methodology

To describe CFC's major developments during 2005-2008, we reviewed CFC reports to CMS, CFC Quarterly Reports, and our ongoing communications with DAIL. Quarterly reports described enrollment trends and numbers by setting and applicants list while CFC reports to CMS described major developments every quarter or sometimes, every six months. We selected and described those developments directly related to the CFC described outcomes.

To describe CFC's progress during the 2005-2008 period, we analyzed available data on the indicators of success as identified in the CFC evaluation plan. Information for indicators derived from our MACRO consumer satisfaction surveys (analytic method to be described below) and SAMS enrollment data and Medicaid spending data as reported by DAIL. As relevant to each desired outcome, we incorporate findings from qualitative data sources (e.g., interviews with stakeholders, analysis of CFC policies) to provide context for our quantitative findings (e.g., from MACRO analysis).

Specific to the indicators based on MACRO surveys, UMMS conducted secondary quantitative analyses of data from the MACRO International, Inc. annual VT Consumer Satisfaction Surveys conducted in October/November of calendar years 2006-2008. Study samples in each year included all CFC clients surveyed by MACRO (moderate, high, and highest needs) providing valid responses. The 2008 sample was further limited to CFC clients with matching Independent Living Assessment (ILA) and SAMS service authorization data. Due to differences in the inclusion criteria and the approach to analysis, the percentages may differ somewhat from the percentages reported by MACRO.² We report the percentage of

² Endorsement percentages on MACRO items reported herein differ from the percentages reported by MACRO in their reports in two ways: 1) Unless otherwise indicated, we report endorsement rates for all CFC participants (moderate,

clients providing valid responses who favorably endorsed survey items, where favorable endorsement was indicated by ratings of “good” or “excellent”, “almost always” or “always”, or “yes” depending on the response scales of individual items. We conducted statistical tests to determine whether there were differences in satisfaction rates across the three years. For 2008 we conducted additional tests to determine whether differences in satisfaction were related to client characteristics (e.g. age, gender, level of need).³ For comparison of differences in endorsement rates across years, a z-test of proportions was used. For analyses of differences in endorsement rates of 2008 MACRO survey items based on client characteristics (e.g., gender, age, level of need), Chi-square tests for statistical significance were used. All tests were conducted using 2-tailed tests at the 95% confidence level.

III. Major Developments and Evolution of CFC (2005-2008)

As reflected in the desired outcomes of CFC, the waiver sought to improve long-term care for older Vermonters and adults with physical disabilities on multiple fronts. Over the three-year period 2005-2008, numerous changes took place to move Vermont’s long-term care system towards these desired outcomes.

Services to Participants

First, CFC added new long-term care options for participants in the high and highest needs groups. Although enrollment into these new service options remained low as of this writing, the additional options advanced the overall long-term care system by allowing participants to choose the way in which to receive supports based on their individual circumstances and preferences. During this time, the following options were developed or piloted:

- Flexible Choices, the Cash and Counseling-based option, began enrollment in year 2 of CFC;
- Policies to allow payment to spouses of CFC participants for their assistance with activities of daily living were fully developed;
- 24-hour residential care option was piloted with two contractors; and
- Program for All-Inclusive Care for the Elderly (PACE) in Chittenden county and parts of Grand Isle county began enrollment while a second PACE site (Rutland county and parts of Bennington county) commenced in February 2008.

In addition to increasing long-term care options, CFC also increased the number of persons served in the moderate needs group (which could also include persons on the high needs applicants list). This was an important development since homemaker and adult day care agencies—providers of moderate needs services—often maintained waiting lists of moderate

high and highest needs) while MACRO did not include analysis of clients who also received home-delivered meals services, and 2) the MACRO endorsement percentages appeared to include all surveyed clients in their denominator, while we analyzed endorsement rates of only clients providing valid survey responses (e.g., cases with missing or non-valid responses were removed from the denominator),

³ For comparison of differences in endorsement rates across years, a z-test of proportions was used. For analyses of differences in endorsement rates of 2008 MACRO survey items based on client characteristics (e.g., gender, age, level of need), Chi-square tests for statistical significance were used. All statistical tests were conducted on weighted samples, applying sample weights provided by MACRO and using 2-tailed tests at the 95% confidence level.

needs participants between July 2006 (when reporting began) and October 2008. Many more moderate needs group participants seeking homemaker services were placed on a waiting list than moderate needs group participants seeking adult day services. The monthly average number of persons on the homemaker waiting list during years 2 and 3 was 155 and 168, respectively. For adult day services, the monthly average number of moderate needs individuals on waiting lists was 9 and 13, respectively.

CFC Operations

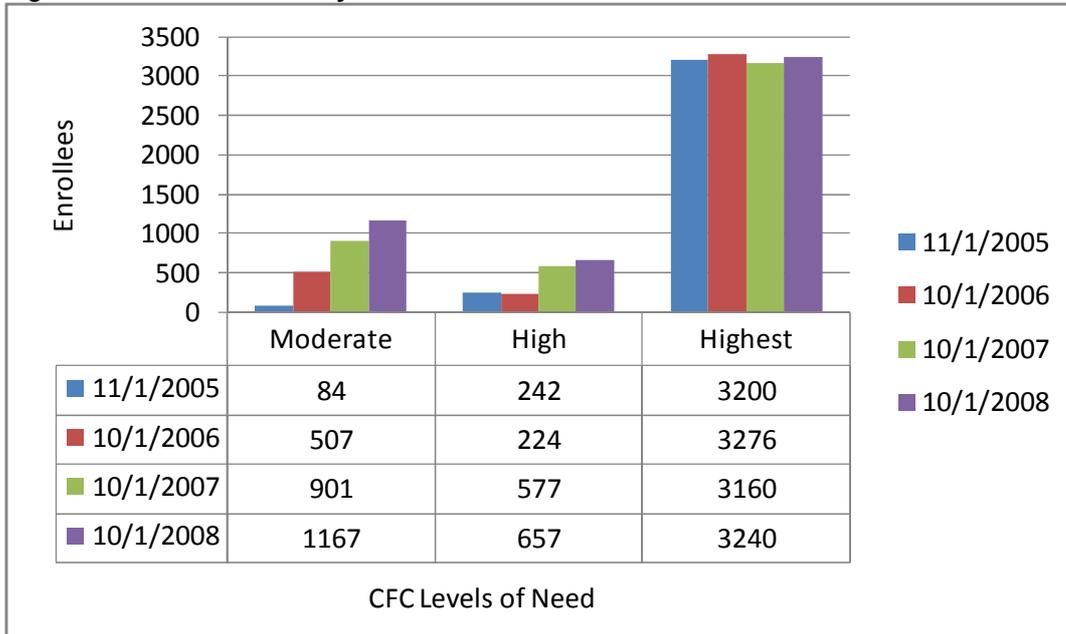
In terms of CFC operations, two major developments occurred in the three-year period. First, in April 2008 (third year), individuals applying for moderate needs services submitted applications with the CFC case management agencies. Up until this time, individuals applied directly with adult day provider and homemaker agencies. The change was instituted in order to have the case manager “take the lead” (Edelman, 2007) in the assessment and clinical need determination process for the moderate needs group and hence improve provider communications.

In addition, in October 2008, on-site quality reviews of home health agencies, adult day providers, and other case management agencies (e.g., Area Agencies on Aging) were suspended in order to review the efficacy of the reviews. (These reviews were formerly conducted by the DAIL Quality Management Unit.) Since then, the Division of Disability and Aging Services has been under active discussion with stakeholders and commissioned a quality management policy brief to identify next steps regarding quality management of CFC. In the meantime, the Vermont Division of Licensing and Protection continued to license home health agencies, ERCs, and nursing facilities while the Division of Disability and Aging Services certified adult day providers and case managers.

CFC Enrollment Trends

Over the period 2005-2008, the bulk of CFC participants were individuals with substantial needs, i.e., individuals who met CFC highest level of need criteria. In years 2 and 3, the moderate needs group outpaced the high needs group in the number of members served. The fluctuations in enrollment in each level of need partly reflect the approach to financing CFC during these years. The Vermont legislature has allocated funding for the moderate needs component of CFC based on past budget line-items for specific services (adult day care and homemaker services.) These funds are then directly allocated to provider agencies. This may lead to waiting lists at one provider and not another, regardless of whether there is a waiting list (applicants list) for high needs clients. In contrast, the overall budget for high and highest needs clients is in a separate line-item. If these funds are not deemed adequate to serve all highest and high needs individuals throughout the year, DAIL may impose a waiting list for high needs applicants in order to assure that expenditures remain within the CFC allocation. This has at times led to a statewide waiting list for high needs clients, even when some providers may have funds available to enroll new moderate needs clients. See Figure 1 for enrollment by level of need from 2005-2008.

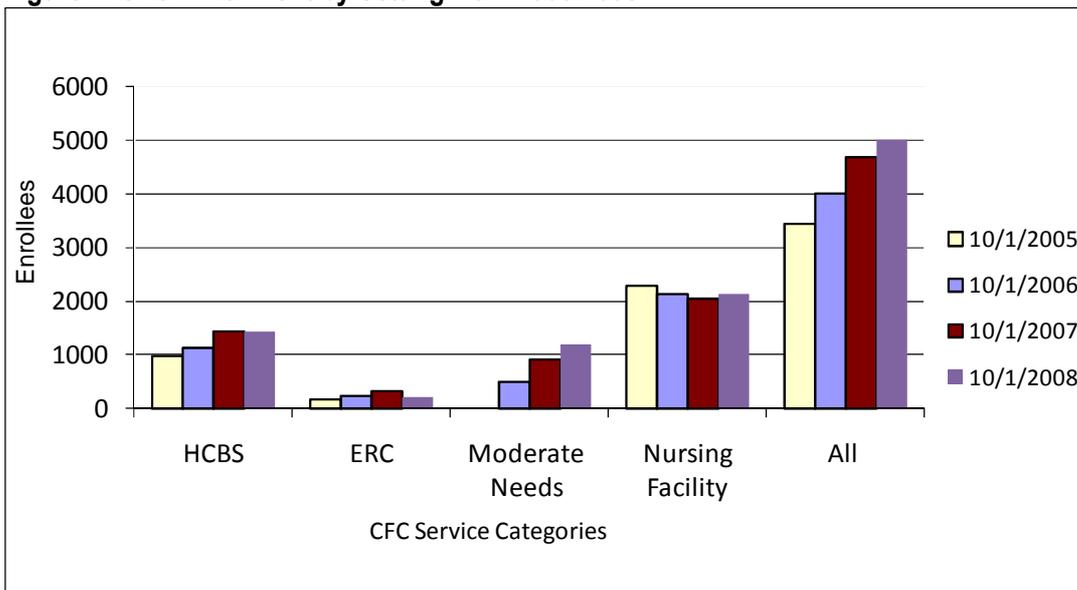
Figure 1: CFC Enrollment by Level of Need from 2005-2008



Note: Enrollment numbers exclude individuals with “short-term” nursing facility and “undetermined” level of need. Some individuals are assessed at several levels of need within a year.

In terms of enrollment by setting, the proportion of enrollment in ERCs and HCBS increased in relation to the proportion of nursing facility enrollment over the three-year period. In terms of the rate of growth, HCBS, ERC, and moderate needs group enrollment all increased rapidly. However, nursing home enrollment still constituted the largest single setting in each of the three years, falling in years 1 and 2, but increasing slightly in year 3. See Figure 2 for point-in-time enrollment levels by CFC settings.

Figure 2: CFC Enrollment by Setting from 2005-2008



Major Evaluation Results and Discussion

IV. A: Information Dissemination Outcome

One of CFC's major goals was to ensure that participants received necessary information and support to make decisions regarding their long-term care setting. CFC has several processes in place to provide ongoing information on CFC options to participants. Specifically, for persons applying to or already enrolled in the highest or high need groups, long-term care clinical coordinators (LTCCCs) provide the first round of options education, followed by ongoing information provision by case managers. For applicants or participants in the moderate needs group, a substantial change was made mid-point in CFC in the way they received options information. Prior to April 2008, adult day care and homemaker agencies were responsible for receiving applications, assessing applicants, and enrollment of applicants in the moderate needs group. As of April 2008, case managers (either from home health agencies or area agencies on aging) became responsible for assessing eligibility of moderate needs applicants and information dissemination to moderate needs applicants or participants in the same way as for their highest and high needs participants. Given the role of case managers in information dissemination, during 2005-2008 CFC launched several major information drives to educate providers about CFC. The first information drive occurred at the time of the waiver's formal commencement. In March 2008, a two-day "Choices for Care 101" training program was held with more than 130 case managers in attendance (Edelman, 2008).

Between late 2007 and early 2008, UMMS and its subcontractor at the University of Vermont conducted interviews/focus groups with consumers and family members, who were asked to evaluate their own knowledge of CFC options. (See the *CFC Stakeholder and Consumer Interview report (2008)* available on the DAIL website for sampling method and detailed discussion of the interviews). Consumers and family members who were interviewed reported knowing that CFC settings included home and community-based options, enhanced residential care, and nursing facilities. At the same time, those interviewed described themselves as less knowledgeable about the newer options such as Flexible Choices. This self-assessment of knowledge was likely due to the fact that CFC's "menu" of services had been expanding since CFC began its formal implementation. Since consumers learn about CFC primarily through case managers, consumer self-reports of their knowledge is consistent with these providers' reporting that their knowledge of CFC's new options was lower compared to their (providers) knowledge of more traditional CFC options, e.g., ERCs, HCBS.

Individual items from the annual MACRO surveys provide an indirect measure of client satisfaction related to information dissemination in the first three years of CFC (see Table 1). In general, we observed increases in satisfaction on these measures from Year 1 to Year 2, which was sustained in Year 3. Two items were added to the 2007 and 2008 MACRO surveys relating to 1) being told of ways to obtain help with ADLs after leaving the hospital, and 2) being involved in decisions regarding help with ADL needs. We observed no significant change from Year 2 to Year 3 on the first item, and nearly all clients who received information regarding ways to meet ADL needs also felt involved with the decision-making process.

The dynamic nature of CFC’s “menu” of options has several implications for CFC in terms of ensuring participants have adequate knowledge to make long-term care decisions. First, as CFC has already done, periodic informational drives can provide uniform information to as many providers as possible at one time, particularly when new options have become available. Second, as the “menu” expands, any “options education”, whether done by LTCCCs or case managers, will take more time. Indeed, since the information conveyed during options education may already be “overwhelming” to participants (UMMS, 2008), a more effective mechanism to disseminate information over time to participants and family members may need to be developed. Third, because case managers are responsible for supporting participants to choose the service setting most suited for the participant’s need and preferences, the preferences and level of knowledge of case managers themselves may affect how options are presented to participants. For instance, interviewees noted that consumer and provider beliefs regarding the effectiveness of different long-term care settings may influence the setting that a consumer chooses. Therefore, CFC should pay attention to educating participants and providers regarding the efficacy of home and community-based care relative to that of institutional care.

Table 1: Summary of quantitative indicators related to information dissemination for the first three demonstration years of CFC.

Question 1.1 To what extent did participants receive information to make choices and express preferences regarding services and settings?			
A. Process Indicators (all from MACRO surveys)	Year 1 (10/2005-9/2006)	Year 2 (10/2006-9/2007)	Year 3 (10/2007-9/2008)
1. Percentage of CFC participants rating “good” or above to survey question that “ <i>people listen to [their] needs and preferences</i> ” with regards to <i>all services they are receiving</i> .	89%	92% ¹	93% ¹
2. Percentage of participants reporting that a hospital staff or Choices representative told them or their family member of “ <i>ways of getting the help [they] needed</i> ”.	a	79%	83%
3. Percentage of CFC participants reporting that they or their family were “ <i>involved in making decisions regarding the help [they] needed with daily activities</i> ”.		99%	99%
B. Outcome Indicators (all from MACRO surveys)	Year 1	Year 2	Year 3
1. Percentage of CFC participants rating “good” or above to survey question that they “ <i>had choice and control when planning for their services</i> ” with regards to <i>all services</i> .	86%	91% ¹	89%
2. Percentage of CFC participants rating “good” or above to survey question that “ <i>services fit in their schedule</i> ”.	86%	90% ¹	90% ¹

^a Shaded cells in the table signify that data were either not collected for that year or were unavailable at the time of this writing.

¹ = indicates statistical difference from 2006 (Yr 1)

² = indicates statistical difference from 2007 (Yr 2)

IV. B: Access Outcome

Timely Access

Timely access to HCBS for highest and high needs participants is a major goal for CFC. Because timeliness may mean different things to different individuals depending on the specific situation, different criteria of timeliness apply to CFC. For instance, a CFC participant with Medicare needing rehabilitation or home health after being discharged from a hospital is likely to receive Medicare supports before needing CFC services. For this person, timeliness of CFC supports may be buffered by the period when the person is receiving Medicare supports. On the other hand, an individual without informal supports or long-term care insurance coverage may find it much more difficult to wait while CFC supports are put in place. Therefore, at the core of the timeliness issue is the extent to which CFC can accommodate these various situations.

CFC has created standards and procedures to assure that the eligibility determination timeline meets some minimum threshold. It has specified that clinical eligibility determinations occur within 30 days of application. Furthermore, CFC has also co-located LTCCCs with the financial eligibility staff at the Department of Children and Families (DCF). Furthermore, to expedite financial eligibility determination for Medicaid long-term care (for highest and high needs applicants), CFC has also allowed individuals with incomes below 100% of the federal poverty level to be exempt from any look-back review (UMMS, 2008a).

By the second year of CFC, state staff had realized that an examination of timeliness of access to CFC services was warranted. Stakeholders, consumers, and family members interviewed in 2007-2008 confirmed that the clinical eligibility determination was considered timely but the timeliness of financial eligibility termination could be improved. In the first quarter of 2006 (year 1), local waiver teams began to implement the 60-day closure policy whereby pending applications were proactively reviewed with the LTCCC, case manager, and other involved staff to assess what was needed to either move the application forward, if it should still be in the application “queue”, or remove the application from the queue so other applications could be reviewed.

As of the end of the third demonstration year, CFC data showed that the number of applications to CFC continued to be at comparable levels to the previous two years (Hill, 2008), suggesting DCF staff's workload was comparable across the three years. During year 2, DAIL had begun to electronically input dates of clinical eligibility determination (dates of financial eligibility determination and application had already been available). In one study, a DAIL external review of a sample of 2007 applications processed by five DAIL offices (Williston, Middlebury, St. Albans, St. Johnsbury, and Newport) found that the average length of time between clinical determination and financial determination was about 66 days. The average length of time from application to full eligibility determination was 106 days (Flint, 2008). In another sample of 272 persons who applied in year 3, it took an average of 36 days between their clinical eligibility determination and their financial eligibility determination while the total application process (from date of application to date of financial eligibility) took on average 48 days (DAIL, 2008). This suggests a dramatic improvement between year 2 and year 3 in terms of eligibility determination timeliness. However, it should be noted that part of this change may be related to the removal of some individuals from consideration due to the 60-day closure policy.

While the time from application to eligibility determination may be influenced by factors within DAIL's control, the time until an individual is fully assessed by his/her case manager and a service plan is developed and services are initiated can contribute to the time an individual is waiting for CFC supports. In year 3, most CFC consumers receiving HCBS continued to report that "services were timely", with 89% saying that "timeliness of services" was either "excellent" or "good" (see Table 2).

Overall, DAIL has taken multiple steps to evaluate and improve the timeliness of eligibility processes. In the Eligibility Policy Brief, UMMS made a number of recommendations regarding improving timeliness, including a presumptive financial eligibility mechanism. In Washington state, presumptive financial eligibility has reduced the average time required to make eligibility determinations from 37 to 17 days (AARP, 2008) while keeping costs to the state to a minimum (3% error rate as of 2006) by training case managers to be conservative (UMMS, 2006). While DAIL has considered this option, due to concerns about cost to the state the Department has not chosen to implement a presumptive eligibility option at this time.

Types of Services

Overall CFC enrollment shows that CFC is increasing access to community care, particularly HCBS. The range of CFC services has also expanded during the first three years, e.g., the addition of Flexible Choices. However, year 2 interviewees noted several challenges related to service access on an individual level. For example, ERCs were not available in some locales nor were ERCs always available when needed (some ERCs had waiting lists). (HCBS, adult day centers, and nursing facilities may be lacking in some geographic areas as well.) Thus, even though an individual may be entitled to all long-term care settings, immediate access to a desired setting in a desired location was not guaranteed. Interviewees also noted the importance of ensuring that adequate cueing/supervision and stimulating social supports were available, particularly for participants with dementia and psychiatric disabilities (O'Connor, Quach, Ingle, and Robuccio, 2008).

To date, CFC has tackled some of these access issues. For example, the number of ERC enrollees climbed dramatically, almost doubling from beginning of year 1 to end of year 3. Secondly, during year 3, CFC began exploring options to expand the 24-hour care option to more individuals, which thus far has been implemented on a very small scale basis with persons with mental illness. It will be important that CFC continues to explore *residential* options for elders/adults with physical disabilities and co-occurring mental illness as well as ways to collaborate with other mental health services to help keep CFC participants in their own homes, if such individuals are not to seek care in nursing facilities. See Table 2 for several quantitative indicators related to access in the first three years of CFC. In terms of measures of timeliness of service and of services meeting their needs, clients reported higher rates of endorsement for Years 2 and 3 compared to Year 1.

Table 2: Summary of quantitative indicators related to access for the first three demonstration years of CFC.

Question 2.1: Are new CFC participants or nursing facility residents who seek discharge able to receive CFC community services in a timely manner?				
B. Outcome Indicators	Data Sources	Year 1 (10/2005-9/2006)	Year 2 (10/2006-9/2007)	Year 3 (10/2007-9/2008)
1. Percentage of CFC participants rating "good" or "excellent" to the "timeliness" of their services.	MACRO Survey	84%	90% ¹	89% ¹
Question 2.2: To what extent are CFC participants receiving the types and amount of supports consistent with their assessed needs?				
A. Process Indicators	Data Sources	Year 1	Year 2	Year 3
1. Average HCBS spending per HCBS participant ³	Medicaid Claims Data	\$2,262 ⁴	\$2,233	\$2,204
2. Average ERC spending per ERC participant	Medicaid Claims Data	\$1,505	\$1,751	\$1,830
B. Outcome Indicators	Data Sources	Year 1	Year 2	Year 3
1. Percentage of participants rating "good" or above to survey question that " <i>services meet [their] needs</i> ".	MACRO Survey	89%	91% ¹	91%

¹ = indicates statistical difference from 2006 (Yr 1)

² = indicates statistical difference from 2007 (Yr 2)

³ HCBS participants include only highest and high needs participants

⁴ Annual averages are the averages of monthly averages in each year

Source: DAIL EDS Claims Monitoring.

IV. C. Effectiveness Outcome

CFC encompasses long-term care services along the entire continuum of settings (from more to less independent settings). Meeting long-term care needs in community settings is particularly crucial to CFC's success because an individual living in a community setting with unmet long-term care needs may be at risk for future admissions into a more restrictive setting. Therefore, CFC seeks to understand whether it is increasing its capacity to serve participants in community settings, whether individuals remain in community settings for longer periods of time (i.e., delays of admissions to other settings), and whether individuals in community settings report that their long-term care needs are met.

Enrollment and CFC service use data during three years of implementation show some promising results.

- From October 1, 2005 to October 1, 2008, nursing facilities continued to be the most frequent setting for enrollees, followed by HCBS, and ERC settings. However, the enrollment trend over this period was an increase in community settings and a decrease in nursing facilities. Specifically, the moderate needs group and highest/high HCBS enrollment increased by 1,200 and 450, respectively. ERC enrollment increased by about 150. Nursing facility enrollment *decreased* from the beginning of CFC to October 2007 to about mid-year 3, but started to climb back up in the second half of year 3 (Hill, 2008).
- Over the same time period, there was a trend for enrollees in HCBS and ERC settings who were enrolled over two consecutive years to stay in these settings longer while nursing home enrollees (enrolling in two consecutive years) stayed in nursing homes for progressively shorter periods of time. For instance, for nursing facility enrollees whose enrollment crossed two consecutive years, their length of stay on average fell from 305 days to 205 days. On the other hand, HCBS enrollees' average length of stay increased from 215 days to 324 days. ERC enrollees' average length of stay also increased from 306 days to 378 days.
- A high percentage of CFC participants across all three years rated the degree to which services met their daily needs as "excellent" or "good" (about 91% in Years 2 and 3, see Table 3). To date this survey has only been administered to CFC participants in HCBS (not in ERCs or NFs).

These results are encouraging signs that CFC is shifting long-term care provision to HCBS and ERC settings. However, because nursing facility enrollment declined only slightly in absolute terms over the three-year period, CFC may want to scrutinize existing nursing home diversion and transition procedures for maximum effectiveness, in tandem with its expansion of HCBS access. See Table 3 for quantitative indicators related to effectiveness in the first three years of CFC.

Table 3: Summary of quantitative indicators related to effectiveness for the first three demonstration years of CFC.

3.1. To what extent are participants' long-term care supports coordinated with each other to provide effective care to participants?					
A. Process Indicators (All from SAMS)		Year 1 (10/2005-9/2006)	Year 2 (10/2006-9/2007)	Year 3 (10/2007-9/2008)	
1.	Average length of stay for HCBS participants who disenrolled in the year immediately following their enrollment year (reported by the year of their disenrollment). ^a	NA	215 days	324 days	
2.	Average length of stay for ERC participants who disenrolled in the year immediately following their enrollment year (reported by the year of their disenrollment). ^a	NA	306 days	378 days	
3.	Average length of stay for NF participants who disenrolled in the year immediately following their enrollment year (reported by the year of their disenrollment). ^a	NA	304 days	205 days	
B. Outcome Indicators		Data Sources	Year 1	Year 2	Year 3
1.	Decrease in number of Medicaid nursing home residents.	SAMS	Decrease of 155 ^e	Decrease of 96 ^f	Increase of 111 ^g
2.	Percentage of participants responding "good" or above on survey item whether their "service meets [their] needs".	MACRO Survey	89%	91% ¹	91%

Sources: UMMS analysis of SAMS enrollment data, DAIL Quarterly Reports

^a Results include only participants whose enrollment date was after October 1, 2005 and whose termination date is in the fiscal year subsequent to the fiscal year of the enrollment date.

^b Snapshot as of 9/06

^c Snapshot as of 9/07

^d Snapshot as of 9/08

^e Difference between 2286 (on 10/1/05) and 2131 (on 9/2006)

^f Difference between 2131 (on 9/2006) and 2035 (on 9/2007)

^g Difference between 2035 (9/07) and 2136 (10/08)

¹ = indicates statistical difference from 2006 (Yr 1)

² = indicates statistical difference from 2007 (Yr 2)

IV. D: Experiences with Care Outcome

Over the three demonstration years, a very high percentage of CFC participants in community settings consistently rated their experiences with care as "excellent" or "good". For example, good or excellent "quality of services" were reported at similar rates across age groups, gender, and case management type, as reported in Section VI. High satisfaction ratings of "courtesy of others" was another sign of CFC success given the important role that interpersonal relationships play in the delivery of long-term care.

While these results are highly encouraging, they do not include two main subpopulations of CFC: nursing homes and ERCs. While some "quality of care" data are collected on nursing homes

in Vermont (Nursing Home Surveys) and nation-wide (CMS' Nursing Home Quality Initiative⁴), ERC residents' quality of care data are not currently collected. Another area to monitor is the difference in participant satisfaction towards quality of services based on whether participants self-direct or receive services through only agencies. Specifically, in 2008, we found that participants authorized for self-directed services were more likely to report satisfaction with their quality of services than participants authorized for agency services (97% versus 90% reporting "excellent" or "good" when rating quality of services). While the ratings from participants with agency-directed services were still high, differences between these two subgroups in other aspects of CFC, e.g., "people listen", "timely services" remained (see detail in Section VI below. Other quantitative indicators related to experiences with care in the first three years of CFC showed high rates of endorsement and improvement over time (see Table 4).

Table 4: Summary of quantitative indicators related to experiences with care for the first three demonstration years of CFC.

Question 4.1: To what extent do CFC participants report having positive experiences with the types, amount, and scope of CFC services?			
B. Outcome Indicators (all from MACRO Survey)	Year 1 (10/2005-9/2006)	Year 2 (10/2006-9/2007)	Year 3 (10/2007-9/2008)
1. Percentage of CFC participants rating "good" or above to <i>"the quality of their services"</i> .	92%	94% ¹	93%
2. Percentage of CFC participants reporting that <i>"courtesy of others"</i> is "good" or above.	97%	98% ¹	98%

¹ = indicates statistical difference from 2006 (Yr 1)

² = indicates statistical difference from 2007 (Yr 2)

IV.E: Quality of Life Outcome

While quality of life depends on many factors, it is reasonable to expect that the range of HCBS that CFC provides may increase participants' quality of life. For instance, personal care, help with Instrumental Activities as Daily Living IADLs, and companion services can be expected to improve participants' ability to meet their basic needs and engage in life activities of their choice. Overall, quality of life showed a significant gain over the three-year period, with 71% and 70% of participants respectively reporting that their "quality of life" was "excellent" or "good" in year 2 and 3; both rates are significant increases from year 1.

Self-reports of more specific aspects of quality of life had smaller gains and satisfaction with specific aspects of quality of life was also found to differ among CFC subgroups.

- In year 3, 78% of participants reported that they had the ability to move around inside their home whereas 67% of participants reported being satisfied with the way they "spent their free time". Only 55% of participants reported being satisfied with their social connections in year 3

⁴ See <http://www.cms.hhs.gov/NursingHomeQualityInits/> for more information.

- Satisfaction ratings for both “quality of life” and “how they spent [their] free time” indicated differences by age (older participants had higher ratings) and gender (female participants had higher ratings) (see Table 1).
- Satisfaction level with “social connections” was comparable across all subgroups, and was comparatively lower than satisfaction level with indoor mobility and with “how free time is spent”.

In interviews conducted in year 2, stakeholders reported that CFC emphasized the personal care side of services more so than the social or quality of life issues for waiver participants, particularly during the care planning process. Furthermore, interviewees in year 2 cited the lack of non-medical transportation as a barrier. These findings were consistent with the MACRO survey results, with the percent of participants expressing high satisfaction with services was higher than that of participants expressing high satisfaction with quality of life. Because social isolation could lead to negative outcomes (Lett, Blumenthal, Bayak, Catellier, Carney, Berkman, Burg et al, 2009) and represents a cause of concern for family members or informal caregivers, it should not be overlooked. In fact, ratings on quality of life survey items were generally substantially lower than ratings on satisfaction with CFC services. Thus, case managers should help CFC participants access available transportation services, companion services, or supports that support quality of life, whether the services are paid by CFC or other sources. That said, self-reported ratings of general quality of life increased significantly from the first year of CFC to the second and third years (see Table 5 for quantitative indicators related to quality of life in the first three years of CFC).

Table 5: Summary of quantitative indicators related to quality of life for the first three demonstration years of CFC.

Question 5.1: To what extent did CFC participants’ quality of life improve over the demonstration period?			
B. Outcome Indicators (all from MACRO survey)	Year 1 (10/2005-9/2006)	Year 2 (10/2006-9/2007)	Year 3 (10/2007-9/2008)
• Increase in percent of participants who rate “good” or better to survey question on their “ <i>quality of life</i> ”.	63%	71% ¹	70% ¹
• Increase in percent of participants who said “yes” to survey question that they are “ <i>satisfied with how [they] spend [their] free time</i> ”.	63%	64%	67%
• Increase in percent of participants who said “yes” to survey question that they can “ <i>get around inside [their] home as much as [they] need to</i> ”.	75%	80% ¹	78%
• Increase in percent of participants who said “yes” to being “ <i>satisfied with [their] social lives and connection to the community</i> ”	55%	54%	55%

¹ = indicates statistical difference from 2006 (Yr 1)

² = indicates statistical difference from 2007 (Yr 2)

IV.F: High Needs Applicant List (and Waiting List) Outcome

High Needs Applicant List

One mechanism that helps CFC to stay within its budget is the high needs applicant list. The applicant list is synonymous with the “wait list” which was changed at the request of Vermont advocates (Edelman, 2009). Individuals are maintained on the applicants list only as long as they continue to meet high needs clinical criteria. If their clinical profile meets highest needs criteria or if they meet any special circumstances, they are enrolled into CFC. The applicant list is activated only when DAIL deems it necessary to control spending. When CFC began in 2005, there were 241 persons on the 1915c waiver waiting lists. With the commencement of CFC, all but 18 of the 241 met highest need criteria and were enrolled. Between October 2005 and December 2006 (about one year after CFC implementation), the waiting list was maintained but eventually fell to zero in May 2007. In February 2008, the applicant list was reinstated and was active as of October 2008 (Edelman, 2009).

During the three-year evaluation period, the average monthly number of high needs individuals on the applicants list progressively declined. The monthly average number of persons on the applicants list was 50, 50, and 35 for years 1, 2, and 3 respectively (averages for years 2 and 3 were calculated by dividing by 7 because each year had five months when the applicant list was zero). In each of the three years, the number of persons admitted from the high need applicant list to nursing facilities versus community settings was relatively evenly split. See Table 6 for the number of persons admitted from the high needs applicant list by CFC setting.

The available data on the average monthly number of persons on the high needs applicant list and the settings into which persons on the applicant list enrolled, combined with total CFC enrollment, suggest that CFC improved access to community-based long-term care over the previous waiver. During year 2, at the recommendation of UMMS, DAIL’s external policy advisor, case managers started using a form to assess whether individuals on the applicants list experienced any changes that would make them qualify for CFC enrollment. Since February 2008, DAIL also started retaining an individual’s past applicant list status and information even after the individual is enrolled in CFC, i.e., the starting date of their applicant list status. This data will allow DAIL to identify *all* applicant list individuals during a given time period, rather than a snapshot of applicant list individuals on a given day. It will also enable DAIL to calculate length of waiting time.

Moderate Needs Waiting Lists

In addition to the high needs applicant list, moderate needs group providers (homemakers and adult day providers) also maintained waiting lists throughout the three-year period. Far more individuals, however, were waiting for homemaker services than for adult day care services in any given month between July 2006 and October 2008, when data were available. In years 2 and 3, homemaker services had a monthly average waiting list of 158 persons and 168 persons respectively versus a monthly average of 8 and 12 persons for adult day services for the same years.

In response to these moderate needs waiting lists, DAIL is exploring mechanisms by which moderate needs participants could self-direct their care plans. Self-direction could help participants find workers (e.g., homemakers) outside of agencies, instead of being placed on waiting list, and thereby potentially increase participant access and satisfaction. Still, it will be important to evaluate the impact of any self-direction option on participants in the moderate needs group. In addition, it will be important for DAIL to understand factors influencing the *adult day* waiting list in particular. For example, is the adult day care waiting list due to available capacity at the adult day centers or to lack of transportation to the adult day site or that the individual center does not have enough funding to serve eligible moderate needs participants? Such investigation can help DAIL identify effective means to address the adult day center waiting list. See Table 6 for quantitative indicators related to the high needs applicant list and the moderate needs waiting lists in the first three years of CFC.

Table 6: Summary of quantitative indicators related to the high needs applicant list and moderate needs waiting lists for the first three demonstration years of CFC.

Question 6.1: To what extent does the implementation of an applicant list for the high need group in Choices for Care have a different impact on applicants waiting to access HCBS vs. nursing facility services?			
A. Process Indicators (all from SAMS)	Year 1 (10/2005-9/2006)	Year 2 (10/2006-9/2007)	Year 3 ^a (10/2007-9/2008)
1. Number of high needs applicants <i>admitted to HCBS under special circumstances during the year.</i>	18	20	12
2. Number of high needs applicants <i>admitted to ERCs under special circumstances during the year.</i>	6	5	4
3. Number of high needs applicants <i>admitted to nursing facilities under special circumstances during the year.</i>	19	25	14
4. Average monthly number of individuals on the high need applicant list.	50 ^b	50	35
5. Average monthly number of individuals on moderate need waiting lists for adult day.	21	8	13
6. Average monthly number of individuals on moderate need waiting lists for homemaker.	83	155	169

^a Sources: UMMS analysis of CFC enrollment data in SAMS and DAIL Reports

^b Calculated using the number of months in the year where the applicant list was greater than 0.

IV. G: Budget Neutrality Outcome

During years 1 through 3, CFC consistently stayed below its CMS projected annual cap for CFC expenditures, while shifting spending more towards community-based spending. However, the CFC budgets developed through the state budget process were set at lower levels than the waiver budgets submitted to CMS, thus ensuring that CFC maintained budget neutrality. Nevertheless, state appropriations as a percentage of CMS waiver projections rose during the first three years, making up 64%, 71%, and 84% in years 1, 2, and 3 respectively. In addition, CFC data shows that long-term care spending for Vermont adults with functional impairments or disabilities

during the three years shifted consistently towards more community-based spending (DAIL Business Office, 2009). This allowed CFC to serve more individuals within the available funds than would have been possible without the waiver, while keeping spending within 1% of the annual state appropriations for CFC.

Table 7: Summary of quantitative indicators related to budget neutrality for the first three demonstration years of CFC.

Question 7.1: 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 waiver?			
A. Process Indicators (all from Medicaid Claims Data)	Year 1 (10/2005-9/2006)	Year 2 (10/2006-9/2007)	Year 3 (10/2007-9/2008)
1. Average HCBS expenditures per HCBS participant	\$2,262 ³	\$2,233	\$2,204
2. Average ERC expenditures per ERC participant.	\$1,505	\$1,751	\$1,830
B. Outcome Indicators	Year 1	Year 2	Year 3
1. Actual annual Medicaid expenditures by CFC do not exceed the projected costs.	Met goal	Met goal	Met goal
2. Annual CFC appropriations (state fiscal year) as a percentage of annual CFC projections (federal fiscal year) to CMS	64%	71%	84%

Source: DAIL Medicaid Claims Report

V. Long-Term Desired Outcomes

Limited data currently exist to determine CFC’s progress towards long-term desired outcomes (public awareness and health outcomes).

- Public Awareness:** During the first three years, CFC focused its attention on its short-term outcomes, e.g., educating CFC participants, in light of stakeholders and participants reporting in year 2 that they had less knowledge about new CFC options. Starting in year 3, the Vermont legislature, and hence DAIL, began to actively discuss ways to increase general public awareness of long-term care service and financing options, including development of a long-term care insurance partnership and/or a long-term care awareness campaign. In anticipation, Vermont had begun gathering, in year 2, some baseline data by asking CFC participants who were hospitalized whether they received long-term care information upon discharge. In year 2, 79% of those discharged from a hospital with a long-term care need reported being given information, with 83% reporting so in year 3 (Table 2). Nearly all of those who received information regarding long-term care upon discharge reported being involved in the decision-making regarding that care.⁵

⁵ No differences by client characteristics were found in how CFC responded to these knowledge questions.

- *Health Outcomes*: In their ratings of “Current Health” in 2008, 64.8% of the oldest participants rated their health as either “excellent”, “very good”, or “good”, compared to 50.9% of older participants and 38.2% of younger participants (Table 8). Statistical differences between each group were significant. In comparison, in 2008, 41.4 percent of DAIL consumers in the Vermont Attendant Services program reported similarly regarding their general health. In contrast, 88.5% of the general Vermont population reported their health as “good” or better, slightly higher than the 85.2% nationwide (Centers for Disease Control and Prevention, 2009). On the health rating item (“Health change from 1 year ago”), a larger percentage of younger participants (34.7%) indicated their current health being “much better” or “somewhat better” than one year ago, compared to 25.8% of older participants and 22.5% of oldest participants (Table 8). In comparison, in 2008, 22.2% of DAIL consumers in the Vermont Attendant Services program reported an improvement in their health.

VI. CFC Subgroup Analysis for Year 3 (2008)

In 2008, the mid-point of the waiver, available resources allowed UMMS to examine in more detail CFC participants’ 2008 responses to the annual consumer survey conducted by DAIL’s contractor, MACRO International. More specifically, UMMS conducted bivariate analyses to examine the variation of survey responses across important CFC client characteristics (e.g., older participants, female participants, moderate needs). UMMS focused on participant responses to specific questions from the MACRO survey selected as indicators of CFC’s progress with respect to seven outcomes (*Information Dissemination, Access, Effectiveness, Experiences of Care, Quality of Life, Public Awareness, and Health Outcomes*). Using merged data from three primary sources (the 2008 MACRO survey responses, Independent Living Assessment (ILA) data for FY2008, and SAMS service authorization data), data from 714 CFC participants were available for statistical analysis. The final sample, with respect to the distribution of clients in terms of level of need and geographic region, was very similar to the sample surveyed by MACRO. Therefore, we would expect that the results found in this analysis would be generalizable to the larger CFC population. For a full description of the methodology, see *2008 CFC Outcomes “At-A-Glance”* (2009) on the DAIL website⁶.

This section describes the specific findings from this data analysis, which are summarized in Table 8 and displayed in a cross-tabulation of each client characteristic variable with each MACRO variable.

Several general observations can be made with regard to the service satisfaction/quality of life ratings in 2008. First, overall satisfaction and quality of life responses across most items were high. That is, most participants, and in some cases nearly all participants, responded favorably to the MACRO survey items. Second, when compared to previous years of CFC, 2008 satisfaction rates were often found to have increased from 2006 ratings, as previously described in Section V. Third, significant differences reported herein should not be interpreted generally in terms of satisfaction vs. dissatisfaction, but rather (in most cases) in terms of differences in levels of satisfaction

associated with various client characteristics. Fourth, while subgroup analysis reveal differences in satisfaction differences by client characteristics, this analysis does not allow us to compare the relative importance of one client characteristic over another with respect to satisfaction/quality of life. Fifth, these differences in ratings based on client characteristics represent only a point-in-time measure and do not necessarily speak to progress towards CFC goals. Future analysis will be required to determine if the satisfaction/quality of life of clients with different characteristics are improving with time under the waiver. Finally, it is important to understand that while analyses based on client characteristics can reflect meaningful differences in the experience of CFC services, they can also represent inherent differences in groups of clients themselves, and we cannot differentiate these in this analysis.

VI.A Gender

Overall, females made up 72.1% of the sample. We found gender differences in MACRO survey item responding within *Information Dissemination* and *Quality of Life* (two of the seven desired outcomes).

- *Information Dissemination*: A larger proportion of females (93.7%) than males (89.3%) responded affirmatively to question “People listen”.
- *Quality of Life*: There were two items endorsed more by females than males. On the overall “Quality of Life” item, 73.7% of females (vs. 64.3% of males) responded affirmatively. Similarly, a larger proportion of females (69.1%) than males (61.1%) indicated that they were “satisfied with how they spend their free time”.

VI. B Age

CFC clients were divided into one of three age categories (18 – 64, 65 – 84, 85+ yrs) for analysis, based on their age at the time of the survey. There were age differences in responses to MACRO survey items across five of the seven indicator categories (*Information Dissemination, Access, Quality of Life, Experiences with Care, and Health Outcomes*), and on ten of 18 individual items.

Within four of the seven categories, we found lower rates of satisfaction (rating “excellent” or “good”) among younger participants than either older or oldest participants. (For some items, younger participants had lower rates of satisfaction than both older and oldest participants).

- *Information Dissemination*: We found differences on both MACRO survey items (“Choice and Control”, and “People Listen”). Only 84.0% of younger participants endorsed the “Choice and Control” item compared to 91.2% and 91.5% of older and oldest participants, respectively. Likewise only 83.6% endorsed the item “People Listen” compared to 95.6% of older participants and 96.5% of the oldest participants.
- *Access*: A smaller percentage of younger participants endorsed the “Services Timely” item (83.1% compared to 90.2% of older participants and 90.8% of oldest participants) and the “Services Fit Schedule” item (86.2% compared to 90.5% of older participants and 95.3% of oldest participants).
- *Quality of Life*: Only 56.5% of younger participants endorsed the overall “Quality of Life” item compared to 73.7% of older participants and 79.2% of oldest participants. Similarly, only 59.5% endorsed the item that indicated satisfaction with “Free Time” compared to

- 70.0% of older and 68.2% of oldest participants. On the third *Quality of Life* measure (“Family/Friend Contact”), a smaller percentage of older participants (64.1%) endorsed the item compared to oldest participants (75.7%).
- *Experiences with Care*: A smaller percentage of younger participants (96.6%) rated the courtesy of those who help them as either “good” or “excellent”, compared to 100% of oldest participants⁷. Still, the courtesy ratings for all three age groups were very high. For the fifth category demonstrating significant differences, the direction of the difference was not consistent. It was striking that the oldest participants were more likely to rate their health as good or better although they were less likely to report that their health had improved over the previous year.
 - *Health Outcomes*: In their ratings of “Current Health” in 2008, 64.8% of the oldest participants rated their health as either “excellent”, “very good”, or “good”, compared to 50.9% of older participants and 38.2% of younger participants. Statistical differences between each group were significant. In comparison, in 2008, 41.4 percent of the Vermont Attendant Services Program consumers reported similarly regarding their general health. (88.5% of the general Vermont population reported their health as “good” or better (Centers for Disease Control and Prevention, 2009). On the health rating item (“Health change from 1 year ago”), a larger percentage of younger participants (34.7%) indicated their current health being “much better” or “somewhat better” than one year ago, compared to 25.8% of older participants and 22.5% of oldest participants. In comparison, in 2008, 22.2% of the Vermont Attendant Services Program consumers reported an improvement in their health, compared to 23.7% in 2007.

VI.C Region

Given the sample size in relation to the number of geographic regions (11), we could not apply statistical tests to determine if there were differences in responding to MACRO survey items by region.

VI.D Level of Need

Across level of need groups (moderate, high and highest), we found differences in responses to MACRO survey items in six of seven Satisfaction/QOL indicator categories (*Information Dissemination, Access, Effectiveness, Experiences with Care, Quality of Life, and Health Outcomes*) and on seven of 18 individual items. We found a general pattern wherein moderate level of need participants reported satisfaction at a lower rate than high and/or highest level of need participants.

- *Information Dissemination*: On the “People Listen” item, a smaller percentage of moderate needs participants (89.9%) responded “excellent” or “good” compared to those in the high needs group (97.2%).

⁷ On this item and six additional MACRO survey items where statistically significant differences were found, the chi-square test result should be interpreted with caution due to at least one cell having fewer than the expected n of at least 5. These six items are denoted with a footnote in the matrix table of results in Table 1 (Satisfaction and Quality of Life Indicators).

- *Access*: On “Services Fit Schedule”, only 87.2% of moderate needs participants rated this item “excellent” or good” compared to 95.4% of high needs group and 92.3% of highest needs participants.
- *Effectiveness*: On the “Services Meet Needs” item, 86.1% of moderate needs participants (compared to 97.1% of those in the high needs group and 95.5% of highest needs participants) gave high marks to this item. This was also the case for the “Help has made your life better” item, where 88.6% of moderate needs participants endorsed the item compared to 96.4% of high needs participants and 94.6% of highest needs participants.
- *Experiences with Care*: A smaller percentage of the moderate needs group indicated that the “Quality of Services” received was “good” or “excellent” (88.0%) compared to 100% of the high needs group and 96.7% of highest needs participants.
- *Quality of Life*: We found level of need differences on one quality of life item “Get Around Inside”; with a larger percentage of the moderate needs group (82.0%) endorsing the item compared to 73.8% of highest needs participants.
- *Health Outcomes*: A higher percentage of high needs participants (36.9%) reported their health as having improved on the “Health Change” survey item compared to the moderate needs group (24.8%).

VI.E ADL Needs⁸

In comparing responses of participants having either low, medium, or intensive activities of daily living (ADL) needs, we found differences on three MACRO survey items, within three indicator categories *Effectiveness*, *Experiences with Care*, and *Quality of Life*. On the *Effectiveness* item “Services Meet Needs”, a smaller percentage of low ADL needs participants endorsed this item (89.2%) compared to participants in the intensive ADL needs group (97.0%). On the *Experiences with Care* item “overall Quality of Services”, a smaller percentage of low ADL needs participants endorsed the item (90.6%) compared to medium (97.1%) and intensive (97.1%) ADL needs participants. Finally, on the *Quality of Life* item “Get Around Inside”, a higher percentage of low ADL needs participants endorsed the item (82.5%) compared to both medium (76.2%) and intensive (63.1%) ADL needs participants.

⁸ ADL needs (low, medium and intensive) and clients’ CFC level of need classification (Moderate, High and Highest) were highly correlated, which was not unexpected given that ADLs are one of the criteria for determining level of need group. Applying the Morris et al. (1999) ADL measure, each level of need group differed significantly from the other on the 0 to 28 point ADL scale, where higher score indicates higher ADL needs: Moderate (Mean=1.17, SD=2.72), High (M=8.60, SD=4.34), Highest (M=16.05, SD=6.46).

VI.F Case Management Setting

Differences in MACRO survey item responses by case management setting were only found on two items, representing the *Information Dissemination* and *Effectiveness* categories. In each case, a higher percentage of clients authorized for area agency on aging (AAA) case management services endorsed the item compared with clients authorized for home health case management services. On the “Choice and Control” item, 92.9% of AAA case management clients endorsed the item compared to 86.8% of home health case management clients. On the “Help has made my life (much/somewhat) better” item, 94.7% of AAA case management clients and 89.4% of home health case management clients endorsed the item. Note: additional testing was conducted to confirm that this finding held true even when controlling for the greater likelihood of AAA case managers to authorize self-directed services.

IV.G Authorized Service Type

The service type analysis compared responses of: 1) clients who were authorized to receive any self-directed services (consumer-directed, surrogate-directed, or Flexible Choices) during the three months preceding the survey; and 2) clients authorized to receive agency-directed services only. We found significant differences on seven of 18 items from five of the seven indicator categories. In each case, a higher percentage of clients authorized to receive self-directed services rated high Satisfaction/Quality of Life compared to clients who were authorized to receive agency-directed services only.

- *Information Dissemination*: A larger percentage of self-directed clients indicated that “People Listen” (96.2%) compared with agency-directed clients (90.3%).
- *Access*: Service type differences emerged for both of the *Access* items. A higher percentage of self-directed clients indicated that “Services (were) Timely” (91.9%) compared to 87.1% of agency-directed clients. Similarly, a higher percentage of self-directed clients indicated that “Services Fit Schedule” (95.4%) compared to 87.5% of agency-directed clients.
- *Effectiveness*: Among self-directing clients, 96.0% indicated that “Services Meet (their) Needs” compared to 88.5% of agency-directed clients. A larger percentage of self-directed clients (95.4%) indicated that the help they have received has made their life “much better” or “somewhat better”, compared to 89.7% of agency-directed clients.
- *Experiences of Care*: Differences were found for one of two *Experiences with Care* indicators. More self-directed clients (97.3%) rated the “Quality of Services” they received as “good” or “excellent” compared to agency-directed clients (89.7%).
- *Quality of Life*: Finally, we found differences on one of six *Quality of Life* indicators. In terms of their satisfaction with “Family/Friend Contact”, 75.8% of self-directed clients and 63.0% of agency-directed clients indicated being satisfied. We did not find differences on the overall quality of life item.

VI.H Moderate Needs Participants

In our sample, 14% of moderate needs participants appeared to have met either high or highest levels of need criteria while the other 86% were moderate needs participants who did *not* appear to meet a higher level of need. This allowed us to test for differences in the two groups’

responses to MACRO survey questions. We found no significant differences in MACRO survey responses to items related to service satisfaction and quality of life when comparing these two groups. The moderate needs category represents both a level of need component and a level of service access component. The presence of statistical difference by level of need for several individual MACRO responses, combined with the absence of statistical difference between the subgroups of moderate needs participants, suggests that service access may be more closely related to service satisfaction than the clinical characteristics that differentiate level of need⁹.

VI.1 Other Data Observations

There were four indicators for which we did not observe any differences in responses based on the client characteristics we analyzed. Specifically, no differences were found for the items “Social Life Connection” (q7h), “Can Get Where Need to Go” (q7c) or on either of the two *Public Awareness* indicators (“Informed of Ways to Get Help with ADLs When Left Hospital” and “Involved With Decision-Making on Getting Help with ADLs When Left Hospital”).

Table 8 provides a summary of the findings of the subgroup analysis for all indicators.

⁹ We however did not attempt to test this proposition statistically.

Table 8 . Satisfaction and Quality of Life Indicators.

	Information Dissemination		Access		Effectiveness		Experiences with Care	
MACRO survey item (Columns):	Choice and Control (q3a) n _{wgtd} =725; %=89.4	People Listen (q3j) n _{wgtd} =738; %=92.6	Services Timely (q3c) n _{wgtd} =742; %=88.5	Services Fit Schedule (q3d) n _{wgtd} =742; %=90.3	Services Meet Needs (q3g) n _{wgtd} =711; %=91.4	Help has made life... (q5) n _{wgtd} =752; %=92.0	Courtesy of others (q3i) n _{wgtd} =751; %=98.1	Quality of Services (q3b) n _{wgtd} =749; %=92.9
Client Characteristics:								
Gender	n/d	Larger % females endorse	n/d	n/d	n/d	n/d	n/d	n/d
Age Group	Smaller % younger endorse compared to older and oldest	Smaller % younger endorse compared to older and oldest	Smaller % younger endorse compared to older and oldest	Smaller % younger endorse compared to oldest	n/d	n/d	Smaller % younger endorse compared to oldest ¹	n/d
Region	***	***	***	***	***	***	***	***
Level of Need	n/d	Smaller % the moderate needs group endorse compared to high ¹	n/d	Smaller % moderates endorse compared to high and highest	Smaller % moderates endorse compared to high and highest ¹	Smaller % the moderate needs group endorse compared to high ¹	n/d	Smaller % the moderate needs group endorse compared to high and highest ¹
ADL Needs (Low, Medium, Intensive)	n/d	n/d	n/d	n/d	Smaller % lows endorse compared to intensive ¹	Higher % medium endorsed compared to low	n/d	Smaller % lows endorse compared to medium and intensive needs ¹
Case Mgmt Type (AAA vs. HHA)	Larger % AAA endorse	n/d	n/d	n/d	n/d	Larger % AAA endorse	n/d	n/d
Service Units (Self-Directed vs. Agency-Directed)	n/d	Larger % of Self-Directing endorse	Larger % of Self-Directing endorse	Larger % of Self-Directing endorse	Larger % of Self-Directing endorse	Larger % of Self-Directing endorse	n/d	Larger % of Self-Directing endorse
The moderate needs group: Meet/Do not meet High Criteria	n/d	n/d	n/d	n/d	n/d	n/d	n/d	n/d
***Did not test for significant differences due to small cell n's								
Note: n/d = no significant differences in % endorsing item.								
¹ Small cell n's; interpret with caution.								

Satisfaction and Quality of Life Indicators, continued

	Quality of Life						Public Awareness		Health Outcomes	
MACRO survey item (Columns):	Quality of Life (q8a) n _{wgtd} =748; %=70.5	Free Time (q7e) n _{wgtd} =742; %=66.8	Get around Inside (q7d) n _{wgtd} =751; %=78.2	Social life Connection (q7h) n _{wgtd} =736; %=55.2	Can get where need to go (q7c) n _{wgtd} =742; %=60.8	Family/ Friend Contact (q7f) n _{wgtd} =743; %=67.9	Informed of ways to get help with ADLs when left hosp. (q8d recoded) n _{wgtd} =185. %=82.7	Involved dec.-making re: ADLs when left hosp. (q8e) n _{wgtd} =143 %=98.6	(Current) Health is... (excellent/ very good/ good) (q8b) n _{wgtd} =747; %=50.7	Health change (1 yr ago) (q8c) n=741, %=27.6
Client Characteristics:										
Gender	Larger % females endorse	Larger % females endorse	n/d	n/d	n/d	n/d	n/d	n/d	n/d	n/d
Age Group	Smaller % younger endorse compared to older and oldest	Smaller % younger endorse compared to older	n/d	n/d	n/d	Smaller % older endorse compared to oldest	n/d	n/d	Larger % endorse at each higher age group	Larger % younger endorse compared to older and oldest endorsement
Region	***	***	***	***	***	***	***	***	***	***
Level of Need	n/d	n/d	Larger % the moderate needs group endorse compared to Highest	n/d	n/d	n/d	n/d	n/d	n/d	Smaller % moderate needs endorse compared to high
ADL Needs (Low, Medium, Intensive)	n/d	n/d	Smaller % endorse at each higher needs level	n/d	n/d	n/d	n/d	n/d	n/d	n/d
Case Mgmt Type (AAA vs. HHA)	n/d	n/d	n/d	n/d	n/d	n/d	n/d	n/d	n/d	n/d
Service Units (Self-Directed vs. Agency-Directed)	n/d	n/d	n/d	n/d	n/d	Larger % of Self-Directing endorse	n/d	n/d	n/d	n/d
The moderate needs group: Meet/Do not meet High Criteria	n/d	n/d	n/d	n/d	n/d	n/d	n/d	n/d	n/d	n/d
***Did not test for significant differences due to small cell n's										
Note: n/d = no significant differences in % endorsing item.										
†Small cell n's; interpret with caution.										

VII. Conclusions and Recommendations

During the first three years, CFC has met its federal waiver obligations. Mainly, CFC remained budget neutral, kept its high needs applicants list “low” relative to the individuals served, and served more individuals than it would have under the previous Medicaid and HCBS waiver service system (nursing facilities and waiver services). Furthermore, CFC also succeeded in its other objectives in that it developed policies on new long-term care options, proactively analyzed the policies and procedures related to eligibility, enrollment, and quality management and evaluated the waiver process and outcomes. At the end of year 3, evaluation results suggest that CFC has increased access to HCBS to its target population, and that the participants were highly satisfied.

At the same time, evaluation results point to areas where additional resources could be devoted in the coming years.

- As CFC HCBS options expand, options education to consumers will continue to be a key CFC process to disseminate information about these options and their relative efficacy. Therefore, it will be important to ensure that all CFC participants benefit from this process, including ERC and nursing facility residents. In addition to educating participants, more outreach to providers, as DAIL had envisioned, should be conducted, particularly with hospital and nursing facility discharge planners.
- DAIL has recognized that timeliness of financial eligibility determination was a challenge. LTCCCs are proactively reviewing pending applications to expedite this process. Another mechanism is financial presumptive eligibility, although this is subject to CMS approval and available state resources. If Medicaid claims data were to contain accurate service initiation dates in the future, such data could be analyzed for service initiation timeliness in future evaluations.
- In terms of CFC services, self-direction has been demonstrated as an effective service mechanism. CFC should ensure this option remains viable and adequately supported. DAIL could study and subsequently evaluate how a self-direction option for moderate needs may improve desired outcomes for moderate needs participants. In addition to self-direction, services that affect quality of life for persons with dementia or other related conditions, compared to personal care services, are also important for the CFC population. Encouraging case management agencies to develop more partnerships with existing organizations may help CFC participants access services not funded by CFC, e.g., services that improve consumer quality of life. In addition, CFC partnerships with local agencies can help nursing home transitions, as some agencies have resources that could be devoted to providing assistance to residents to find housing and funding to pay for rent deposits. Such efforts can help leverage available resources for CFC participants without increasing CFC funding.
- A review of high needs applicant list data in SAMS and case managers’ monitoring worksheets with high needs applicants (e.g., start and end dates on applicants list) will provide DAIL with a better understanding of the number of persons on the applicant list, duration of being on that list, and assistance individuals receive while waiting for CFC services.
- As described previously, the development of a long-term care partnership (e.g., incentives for purchasing long-term care insurance) has recently begun in Vermont. Assuming that this effort is fully

developed, DAIL should conduct a related public awareness campaign building on its experiences with educating community participants on CFC options. To help assess the success of public awareness campaigns, DAIL should also gather information of the general Vermont public awareness of long-term care options. A public awareness campaign could first be piloted with moderate needs applicants and their family members. The moderate needs group participants may be a logical place to start because many of them have lower levels of need and do not qualify for Medicaid, thus they, more so than the highest/high participants, may more closely resemble the general Vermont population with potential or current long-term care needs.

- While much attention and resources have been devoted to HCBS settings and participants, it is important to pay attention to nursing facility and ERCs in terms of implementation and evaluation. Specifically, education of nursing facility residents (directly or through nursing facility and hospital discharge planners) should be conducted in tandem with the education of HCBS participants. In addition, service satisfaction and quality of life of participants in ERCs and nursing facilities (long-term participants) are as important as those of HCBS participants, and evaluation resources should be allocated to be inclusive of all CFC settings. Future data collection could include interviews with ERC residents as well as electronic input/analysis of ERC and nursing facility resident assessment data. In addition, Medicare and Medicaid claims analysis for the entire CFC population with outcomes related to nursing facility usage and preventable hospitalizations can shed light on the long-term impacts of CFC. Although multiple evaluation initiatives require resources (resources could be identified within Vermont or from external funders), evaluations can demonstrate CFC impact on outcomes (important in state budget justifications) and identify areas for improvement to make the best use of available resources. Thus, evaluation findings will not only be valuable to Vermont, but also contribute to general knowledge and hence be valuable to both CMS and other states.

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