

Vermont 1115 Waiver Demonstration

Choices for Care Semi Annual Report January 2008 – June 2008

This report covers the second and third quarter of the Choices for Care waiver in the third year of operation. A description of major accomplishments and activities follows.

HIGH NEEDS WAIT LIST

At the sixth month mark for SFY 2008, DAIL determined that the current trajectory of spending would put the Choices for Care Long Term Care budget over the appropriated amount by the end of the fiscal year unless measures were taken to control spending. This was a rapid discovery from what was reported in the previous two quarters. There was confusion surrounding how the CMS 64 Reports assigned claims and what information was reported between the two Vermont 1115 waivers. Several other situations changed the financial picture: more expensive out of state placements than anticipated, a higher rate of enrollment in the High Needs Groups than anticipated and the full annualizing of individuals who came off the High Needs waiting list the previous Spring. This necessitated the re-establishment of a High Needs wait list, as indicated in the Operational Protocol. In February 2008 DAIL reinstated a wait list for individuals who meet High Needs clinical criteria. The program regulations include the ability to enroll certain individuals on the wait list, under “special circumstances”, e.g. loss of a primary caregiver. During this reporting period 41 individuals were placed on the High Needs wait list and 23 individuals were admitted to the program under the special circumstances provision. The ability to create a waiting list, when needed, was an essential element of the original Choices for Care waiver proposal and was approved by CMS and the Vermont Legislature. Even with the waiting list, the 1115 waiver is serving more people than planned.

MODERATE NEEDS

The last report discussed proposed changes to the Moderate Needs enrollment process. Some providers had difficulty understanding the rationale behind

modifying the procedures. To briefly recap, a representative work group met over the course of a several months, the purpose of the group was to examine the application and accessing services process for consumers as well as communication and flow of information for both consumers and providers. The majority of the workgroup members agreed that Moderate Needs individuals would be better served if they were all to enter the program through the case management system. This would allow for a more coordinated approach to assessment and determination of needed services. While there were representatives from all Moderate Needs Group providers, several did not support that change. In April, the change was instituted. The DDAS Division Director spent the next three months meeting with all the provider groups, soliciting their input and analyzing the impact of this change. Internally, staff monitored the progress of applications in terms of timeliness, duplication of efforts and clarity for the consumer. In June the Division decided to retain the changes established as a result of the Moderate Needs review workgroup. Since that time, the system appears to be working more efficiently and effectively for all.

CHALLENGING PLACEMENTS

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

A protocol was developed to assist the Vermont State Hospital in managing discharge planning for these individuals. This protocol is in the process of being modified to be used as a model for the Department of Corrections. The use of the protocols has helped the State Hospital and Corrections staff in appropriately accessing the provider network in the course of their discharge activities; however, the ongoing challenge is the availability of appropriate service providers for this challenging set of individuals.

In an effort to develop new provider capacity, DAIL drafted an *Individualized 24 hour Care* option that was submitted to CMS for review on August 7, 2008. The full implementation of this option is limited in part by concerns brought to DAIL from the providers who are participating in the test model currently underway. These providers rely on contracted home providers as the base of their service delivery system. Providers have made it clear that they can not afford to offer this service without a funding mechanism that would allow them to continue to reimburse their home providers for a period of time (typically up to 30 days) while a client is in the hospital or in a temporary nursing home stay. To address this barrier, DAIL submitted a proposal for consideration by CMS, to provide a Personal Care Capacity Payment. CMS is currently reviewing this request.

MYCARE

For over three years, DAIL has been working on a Real Choices System Change grant, with the goal of creating an integrated system of care for acute/primary care and long-term care service delivery for elders who are frail, at-risk or chronically ill and adults with physical disabilities. This project is similar to a rural PACE model and has been named "MyCare". An RFP was issued for providers to develop business plans to determine the feasibility of their organization providing integrated services. There were no successful bidders to this RFP. The grant funding ends September 29, 2008.

QUALITY MANAGEMENT

The Quality Management Unit is responsible for monitoring the Choices for Care providers (excluding Enhanced Residential Care Providers and Nursing Facilities, which are surveyed by the Department's Division of Licensing and Protection). Implementation of the Quality Management Plan and its review processes were implemented in July 2007. During this reporting period, nine (9) Choices for Care (CFC) service providers and 66 participants were reviewed.

The QM reports are comprised of three areas of review: (1) Quality Services Reports which convey the manner in which DAIL documents outcomes for service providers and participants; (2) Quality Action Plans which describe areas for change and how service providers will make improvements to

services based on the Quality Services Reviews; and (3) a summary of participant responses to individual interview questions.

During the first six months of implementation it became apparent that the Quality Management Plan required a change regarding the language that is used to categorize review findings. The language was confusing and caused a need for additional time for review staff. The Quality Management Unit brought this issue to the Quality Management Committee after seeking feedback from several providers, other DDAS staff as well as brainstorming some ideas to present to the committee. The committee made recommendations back to the Quality Management Unit and changes were made to the language for review findings.

The Quality Management Plan now has three types of findings:

Critical Finding: This finding is urgent and needs immediate attention because a consumer is in immediate jeopardy or other critical circumstances are found. These findings are reported to the agency for immediate follow-up as soon as they are found. Documentation of follow-up by the agency must be furnished to the State within one week of the finding. Critical Findings and the steps the agency took to resolve the issue are included in the Quality Services Report.

Area for Improvement: This is a finding that requires a change in practice by an agency. The Area for Improvement may be on an individual level or systemic in nature. The agency is required to respond through their Quality Action Plan by describing how they will remedy the issue, the timeline and person(s) responsible for addressing the issue.

Recommendation: This is a recommendation from DDAS to an agency concerning use of a positive practice or for a suggested improvement in an agency's practice. The agency is not required to respond to recommendations in their Quality Action Plan.

DDAS continues to meet quarterly with the Long Term Care Ombudsman to discuss Ombudsman findings and possible improvements to the Choices for Care program. All complaints by consumers in the Choices for Care program

are brought to the Ombudsman are reviewed. The Quality Management Unit continues to assess individuals' knowledge of the Ombudsman during the Quality Services Review as well as provider agency processes to ensure information on how to access Ombudsman services are disseminated at intake and annually to consumers.

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

FLEXIBLE CHOICES

Flexible Choices is Vermont's version of the "Cash and Counseling" model, in which an individual's service plan is translated into a person-centered budget. The Flexible Choices option allows for more flexibility in purchasing services and goods that the individual has determined will meet his/her unique needs. This often involves services and goods that are not available under the "traditional" program, but are necessary for the care and support of the individual.

For Flexible Choices, the theme for the last six months has been Achieving Maturity. In other words, this option has moved from being a poorly understood novelty to a full-fledged, if small, part of the Choices for Care range of options. This maturing has been marked by the following characteristics:

- Slow, steady growth
- Integration into basic training about Choices for Care
- Refinement of budgeting and spending protocols.

In parallel with these changes, and with support from the Robert Wood Johnson Foundation Cash and Counseling Grant, DAIL has been working to develop a Direct Care Worker Registry. (See section below.)

On January 1, 2008, Flexible Choices had enrolled 40 people over the lifetime of the option and 33 people were receiving services at that time. As of June 30, 2008, the program had a lifetime enrollment of 64 and 54 people were receiving services. While these are still small numbers, the data do represent a 60% increase over six months with an average of four new enrollees per month, i.e. there were as many new enrollees in six months as the program enrolled in its first year. At this point, DAIL expects this growth to continue. While we do not expect any sudden growth spurts, we see a continuing interest across the state from consumers who have a specific need that is not covered by the traditional home-based service option. On the other hand, the traditional option covers a broad range of services, allows for consumer or surrogate direction and can be fairly flexible, so there is not a large pool of dissatisfied Choices for Care participants wanting an alternative way to obtain their services.

In March, the DAIL staff conducted two sessions of a two-day “Choices for Care 101” training program. Over 130 case managers from around the state attended. Flexible Choices was included in the training. This was the first opportunity to present Flexible Choices simply as a component of Choices for Care (which, of course, it is) and not as something added on or separate. Case managers responded positively to these presentations, displaying an understanding of what the option offers and whom it can help.

The guidelines for budget development and spending were initially designed to be broad because we knew we were working with a small number of recipients and we would be able to make individualized decisions. As a body of knowledge developed, we have been able to refine our policy guidelines. This has allowed the Consultants to function more autonomously and respond more quickly and accurately to consumer questions.

A continuing challenge is working with the fiscal ISO concerning budget monitoring, in particular, monitoring more closely to ensure that consumers do not overspend and to design a system to limit accumulated savings as delineated in policy.

DIRECT CARE WORKERS' REGISTRY

DAIL is finalizing a contract with Rewarding Work Resources, Inc. to develop a web-based Direct Care Worker Registry. This contractor has developed registries for several other states. The registry will be launched in the fall, with the development of software and marketing materials occurring over the summer. The registry is designed to serve employers (both individual and organizational) and workers throughout the state and to facilitate employers finding workers. Equally important, it is designed to help workers find work and, we hope, be able to move from part-time to full-time care giving. While the Direct Care Worker Registry will affect programs across DAIL, some support for it comes from the Cash and Counseling grant and well as a DCWDCW Institute TA Grant.

PACE VERMONT

On March 1, 2008 PACE Vermont expanded their program to include a satellite site in Rutland. As of July 1, 2008 PACE Vermont's Colchester site had an enrollment of 31 participants and the Rutland site has an enrollment of 5. Updated enrollment projections anticipated enrollment numbers of 35 at the Colchester site and of 9 at the Rutland site. These new enrollment projections were issued by PACE Vermont in February 2008 and were based primarily on the delay in opening the Rutland site and the slower than projected growth in enrollment at the Colchester site.

After significant challenges during their first year of operations, the PACE Vermont Colchester site is now fully staffed. The Colchester site plans to expand the social worker position from a half-time to a full-time position. PACE Vermont will also recruit a new Intake Coordinator for the Colchester site. The current Intake Coordinator will be moving into the new Director of Marketing position. The opening of the Rutland site was delayed until March 1, 2008 related to finding, hiring and training staff. The Rutland site is now fully staffed.

In early May the national and regional CMS teams spent three days at PACE Vermont on a technical visit. Recommendations from CMS were presented to the PACE Vermont team with responses to be provided to CMS within 30 days. Incomplete or missing contracts were to be updated and provided to CMS within 90 days. PACE Vermont has responded to the 30 day deadline

and anticipates having all contracts in place and updated in time to meet the 90 day deadline.

As a rural PACE operation, PACE Vermont, is facing a large challenge in regard to transportation for PACE participants. Transportation providers use economies of scale in providing rural transportation. These practices do not necessarily meet PACE regulations. PACE Vermont is investigating what options might be available to address these concerns. Possible alternatives being investigated include building a partnership with a new transportation provider and the possibility of PACE Vermont providing transportation services directly.

During the first quarter of 2008, PACE Vermont ran an operating loss of just under \$250,000. This loss, in conjunction with an operating loss of about \$160,000 during 2007, led PACE Vermont to update their fiscal projections. PACE Vermont now estimates that their break even date will be around May 1, 2009. This date has been pushed back considerably from the initial pro forma information.

To address these fiscal challenges, PACE Vermont has begun investigating the potential of other out-of-state PACE programs investing in PACE Vermont. Additional grant funding from the Rural PACE grant is being pursued as well and funding through the Tarrant Foundation, a Vermont foundation. PACE Vermont has also approached their landlord, the Fanny Allen Corporation, for an extension of PACE Vermont's current rent abatement.

ELECTRONIC ASSESSMENTS

DAIL would like to establish a system that would allow for all Independent Living Assessments (ILA's) to be completed electronically. The goal is to move toward a paperless system for all client assessments. A pilot is currently being underway in Caledonia County. The challenge in developing this system is business process issue, i.e. who will do what with which forms and data. The pilot will not be fully implemented for several months and will begin with the Home Health Agency, then add the Area Agency on Aging followed by the Adult Day Program. Nursing Homes, Enhanced Residential Care settings and the Department for Children and Families (the department that does long-term care financial eligibility determination) will come on board as the project develops. Assuming that the pilot succeeds, we would look to replicate it in additional regions.

EVALUATION

On June 15, 2007 a contract was awarded to the University of Massachusetts Medical School, Center for Health Policy and Research (CHPR), to undertake the evaluation of Choices for Care. The contract requires a multi-level approach, CHPR, working with the University of Vermont, has completed focus groups and interviews of consumers, family members, providers, and state staff. These focus groups are intended to identify and elucidate issues related to the implementation and management of Choices for Care.

Additionally, CHPR completed a logic model and evaluation plan to guide the Choices for Care evaluation. The evaluation plan includes the Choices for Care goals, evaluation goals and performance indicators, system outcomes and measures, consumer outcomes and measures, a strategy for identifying predictors of nursing home use, methods of data collection, and methods of data analysis. This document is intended to contribute to discussion and input into the development of the evaluation plan.

In early January, CHPR held a two-day round table discussion to review and refine that plan. Attendees included DAIL staff, Vermont advocates and expert discussants. The purpose of the session was to ensure evaluation questions and design, including indicators, data sources, and analytic approach are robust and feasible based on the desired outcomes.

The following documents are included under separate cover:

- ✓ Choices for Care Quarterly Data Report – July 2008
- ✓ Choices for Care Quarterly Data Report – April 2008
- ✓ Choices for Care Evaluation Qualitative Data Analysis
- ✓ Choices for Care Evaluation: Roundtable Summary
- ✓ Choices for Care Technical Assistance First Bi-Annual Report
- ✓ Choices for Care Technical Assistance Second Bi-Annual Report
- ✓ Choices for Care Policy Brief: Eligibility