

The Vermont Long-Term Care Plan:

A Demonstration Waiver Proposal to the Centers for Medicare and Medicaid Services

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EXECUTIVE SUMMARY

The State of Vermont has a long history of significant health care reform and expansion of health coverage for its uninsured residents. Building on the substantial achievements of the Vermont Health Access Plan Demonstration Waiver, the State is now turning its focus to the long-term care arena. This proposal for a long-term care demonstration program is the result of a year-long planning and development initiative. The proposed program addresses both shortcomings in service availability and the inherent bias in the current funding mechanisms for long-term care.

This Demonstration is aimed at giving adults with physical disabilities and the frail elderly real choices. That means giving them the option to receive the long-term care services they need in a home- and community-based setting without having to wait for a “slot” to open up in a 1915(c) waiver program, or to choose care in a nursing facility. Individuals who can maintain themselves in the community, with home- and community-based services should have that option. Often, under the existing federal Medicaid system, this important goal cannot be achieved. Therefore Vermont is proposing a bold new approach to the delivery and financing of long-term care services for adults with physical disabilities and the elderly.

The long-term care program described in this Demonstration Waiver proposal will constitute a wholesale replacement of most of Vermont’s existing Long-Term Care Medicaid program. All individuals currently eligible for Medicaid and in receipt of long-term care services in a nursing facility, HCBS Waiver or ERC Waiver, will be enrolled in the demonstration. The program will be administered by the Department of Aging and Disabilities, within the Vermont Agency of Human Services – the single state agency for Medicaid in the State of Vermont. It will be operated as managed care model under a global budget.

The primary goals of the demonstration are to provide consumers with equal access to long-term care options (nursing facility and home- and community-based services) and promote early intervention for at-risk populations.

The Demonstration is designed to test the hypothesis that targeted early interventions, assessment, case management and the provision of home- and community-based services to the frail elderly and physically disabled adults will:

- ensure enrollee satisfaction with the long-term care services received;
- reduce utilization of institutional settings; and
- control overall costs for long-term care in the State.

Under this demonstration Vermont will seek to create a program without institutional bias, financial or otherwise. It is specifically designed to help elders and younger adults with physical disabilities to live as independently as possible for as long as possible, in the settings of their choice.

Vermont also recognizes that funding constraints are a reality. Accordingly, it has developed a prioritization strategy which ensures that those with the “highest needs” are served first and to the full extent of their needs. The program categorizes eligibles into three distinct groups: Highest Need; High Need; and Moderate Need. High and Moderates Needs groups are further prioritized and individuals are served based on the level of available resources.

The “Highest Need” group will be entitled to either nursing facility or home- and community-based care. This entitlement to either setting represents a dramatic change in the way long-term care services are provided in Vermont. Today approximately 2,200 individuals are benefiting from the entitlement to nursing facility care. With this change in entitlement, Vermont projects that nearly 3,000 individuals will benefit from the broader entitlement to both nursing facility and HCBS by allowing the additional 800 individuals equal access to either category of service. All Demonstration participants in the Highest Need group must also meet the financial eligibility criteria for Vermont long-term care Medicaid.¹ Vermont anticipates that given equal access to either nursing facility or home-based care, more individuals will choose home- and community-based care. This will allow the State to serve more individuals for the same amount of money.

¹ The one exception is with respect to resources. Demonstration participants electing home-based services may retain up to \$10,000 in resources.

The High Needs Group will not be legally “entitled” to long-term care services, but will be served to the extent that funds are available. These individuals will also have to meet existing long-term care Medicaid financial eligibility criteria,² but will not have care needs at a level which meets the existing clinical criteria for long-term care Medicaid. Given historical utilization, the State expects that this group will consist of approximately 200-300 individuals each year. Vermont fully expects that the individuals in this subgroup will all be served under the waiver; however, there is the remote possibility that they would not be served if there were no funds left after serving the Highest Need group. These individuals would still be eligible for the many home- and community-based and Medicaid State Plan services that would continue outside this Demonstration.

The Moderate Needs group will include individuals who do not meet current nursing facility or HCBS Waiver eligibility criteria, but are believed to be at risk of institutional placement based on their assessed care needs. Vermont believes that if services can be provided to these individuals earlier than the current practices allow, their conditions can be stabilized or improved, thus avoiding or delaying more costly institutional care. These individuals will be assessed and provided with preventive and supportive services necessary to help maintain their well being and independence. This might be as little as a weekly homemaker visit, or a monthly case management visit. They will be served to the extent funds are available after serving all eligibles in the Highest and High Need groups.

In summary, the Demonstration offers the Department of Health and Human Services and the Centers for Medicare and Medicaid Services the opportunity to test a new and innovative model of long-term care service delivery and financing. The imperative exists. There will be incredible pressure on the long-term care financing system under Medicaid as the “Baby Boom” generation ages. This demonstration has tremendous merit and will provide invaluable experience and data to assist HHS and CMS in their planning efforts and policy-making activities going forward.

² Ibid 1

Chapter 1: Background and Description of the Demonstration

Background

The Vermont Health Access Plan (VHAP) was implemented under the auspices of a Section 1115 Research and Demonstration Waiver granted to the State in 1995. The overarching goal of that waiver was the restructuring of the State's publicly funded health care system to maximize the number of persons with health coverage, while spending no more than would have been spent under the pre-waiver program.

Concurrent with VHAP implementation, the Vermont Legislature, in its 1995-1996 session, passed Act 160, "An Act Relating to the Coordination, Financing, and Distribution of Long-Term Care Services." Act 160 lays out the State's overall strategy for restructuring Vermont's long-term care delivery system.

Under the Act, the Agency of Human Services (AHS) was instructed to gradually reduce Title XIX nursing home expenditures during Fiscal Years 1997 – 2000 by an amount equivalent to eliminating 234 beds (or about six percent of all beds in the State). The Agency was further directed to shift the dollars associated with those reductions to fund the expansion of home- and community-based (HCB) services.

The total number of nursing facility beds in the State has declined to 3,600; a five percent reduction from their peak in 1996. Occupancy has also declined and now stands at 3,250 (90%). However, the recent decline in nursing facility utilization has now leveled off.

The relatively modest progress Vermont has made in reforming its long-term care system is now threatened by State budget problems. To help balance the State's budget, the Agency of Human Services, through the Department of Aging and Disabilities, (DA&D) may be forced to reduce funding allocated to the HCBS programs to ensure that sufficient dollars are available to finance the existing entitlement to nursing facility services. Ironically, this circumstance sets up a cycle that ensures that the ultimate goals sought by both the state and federal government cannot be achieved.

As a solution to this situation, the Vermont Agency of Human Services is proposing a broad-based program of long-term care reform. The reform program being proposed addresses both shortcomings in service availability and the bias inherent in the current funding mechanisms for long-term care.

The Legislature has authorized the Agency to seek the federal waivers necessary to support the development of a stronger, more comprehensive HCB service infrastructure within the State. The starting point was to be Vermont's existing 1915(c) waivers, two of which target elderly persons and physically disabled adults³.

The larger of those two waivers was most recently renewed in Calendar Year 2002 and grants Vermont the authority to offer a continuum of HCB services to individuals eligible for Title XIX and found to be eligible for nursing facility level of care. The specific HCB services covered under that waiver are: case management; personal care; respite care; adult day care; companion; personal emergency response system; and assistive devices/home modifications. The waiver currently has 978 slots and serves approximately 1,500 individuals per year.

The second 1915(c) program is a model waiver authorizing enhanced residential care services for elders and younger adults with physical disabilities (Enhanced Residential Care - ERC Waiver). It was approved by the Centers for Medicare and Medicaid Services (CMS - then HCFA) in March 1996 and has since obtained status as a 5-year waiver that is capped at 200 enrollees. This waiver currently has 146 slots and serves approximately 210 individuals per year. Vermont is in the process of renewing the waiver for this program, which has operated successfully.

Eligibility criteria for nursing facility and home- and community-based services are currently the same, and all clinical eligibility decisions are reviewed and approved by the Department of

³ Vermont also has 1915(c) waivers for MR/DD clients, for individuals with traumatic brain injury and for children.

Aging and Disabilities. The Department of Prevention, Assistance, Transition and Health Access (PATH) determines financial eligibility. Eligible consumers are given a choice between nursing facility care and the services available through the Enhanced Residential Care Waiver or Home-Based Waiver.

The State currently determines clinical eligibility for these two waiver programs using a comprehensive assessment instrument known as the “Independent Living Assessment” (ILA). The ILA captures information on an individual’s functional status (ability to perform Activities of Daily Living and Instrumental Activities of Daily Living), cognitive/emotional status, health status and medical conditions, home environment, and informal social supports. A home health Registered Nurse or Area Agency on Aging case manager administers the assessment. An RN always administers the section on health status and medical conditions. The assessment is administered in collaboration with the applicant and/or family members and is designed in part to assist in selecting a service setting and range of services based on needs identified through the ILA. Final approval of the HCBS plan of care or approval for nursing facility care rests with the Department of Aging and Disabilities. The ILA is appended to this proposal at Appendix A.

The Vermont Legislature’s strong commitment to expanding HCB services in the State offers a unique opportunity for testing a “preventive” long-term care model – one built around HCB services. That model is included as part of this Demonstration Waiver proposal.

The overriding goal of the proposed Demonstration is the expansion of choices for consumers. The State of Vermont is committed to offering its elderly and adult physically disabled residents a comprehensive array of options designed to deliver the services they need. Vermont intends to do this by continuing to expand and build upon its existing home- and community-based services, while at the same time continuing to ensure the availability of quality nursing facility care. The specific programmatic objectives for the Long-Term Care Demonstration project are:

- Contributing to existing research and practice regarding which functional, cognitive, and medical measures are the best early predictors of individuals at risk for institutional placement in the short to medium term.

- Testing the hypothesis that it is more cost-effective to furnish a package of HCB services to individuals, based on their specific needs, than to operate a system where there is a bias for institutional options.
- Testing the related hypothesis that a limited package of HCB services, if furnished early enough, can significantly delay or eliminate the need for nursing facility placement and result in a net savings for the State and federal governments.
- Improving the quality of life and degree of independence for low-income elderly persons and adults with physical disabilities, by helping them to maintain the highest possible degree of functioning while living at home, or in a home-like setting.
- Facilitating the further growth and development of home- and -community based services and resources throughout the State.
- Testing the effect of greater consumer control and choice on quality and cost.

Description of the Demonstration

Overview

The long-term care program described in this Demonstration Waiver proposal will constitute a wholesale replacement of most of the existing long-term care Medicaid program in Vermont. All individuals currently eligible for Medicaid and in receipt of long-term care services in a nursing facility, HCBS Waiver or ERC Waiver will be enrolled in the demonstration. This includes persons currently enrolled in the State's existing HCBS waivers and nursing facility residents, but excludes enrollees in any Program for the All-Inclusive Care of the Elderly (PACE) program that may be operated in Vermont or those persons screened out through the Pre Admission Screening/Annual Resident Review (PASARR). Vermont has also submitted a proposal to CMS for the "Vermont Independence Project- VIP", which asks for Medicare reimbursement for case management services to assist individuals to manage their chronic disease. If this program is ultimately approved, the Medicare funds associated with case management services for the approved population will be rolled into this waiver.

Future Medicaid applicants who require long-term care services will also be enrolled in the demonstration. Vermont will use its existing Utilization Review process to determine whether individual Medicaid recipients who are residents of a nursing facility at the time the demonstration is implemented have the potential for returning to a home or other community setting with HCB services.

The program will be administered by the Department of Aging and Disabilities, within the Vermont Agency of Human Services – the single state agency for Medicaid in the State of Vermont.

The goal of the demonstration is to provide consumers with choice through equal access to long-term care options (nursing facility and home- and community-based services). Vermont will accomplish this by providing equal access to long-term care services and by expanding eligibility for a variety of long-term care services for its citizens under the proposed Vermont Long-Term Care Research and Demonstration Waiver.

The provision of expanded home- and community-based services will be enacted through a new Section 1115(a) Research and Demonstration waiver program. This waiver proposal describes the expansion, its objectives, and its “fit” within Vermont’s other health care reform initiatives.

The Demonstration is designed to test the hypothesis that targeted early intervention, assessment, case management, and the provision of home- and community-based services to the frail elderly and disabled adults will:

- ensure enrollee satisfaction with the long-term care services received;
- reduce utilization of institutional settings; and
- control overall costs for long-term care in the State.

In addition to the objectives previously outlined, there are also five overall goals for the proposed long-term care demonstration program, as follows:

- provide equal access to long-term care options;
- better manage the state's soaring long-term care expenditures;
- provide preventive services to an expanded group of individuals with the goal of preventing or delaying the need for more costly services;
- under a "Cash and Counseling" pilot, provide Medicaid services tailored to the consumer's unique needs and preferences, rather than what is permissible under rigid state plan rules; and
- encourage early planning for future needs, by offering financial incentives to encourage the purchase of private long-term care insurance.

Past attempts to provide consumers with meaningful options have often been thwarted, to some degree, by the very nature of the current long-term care financing mechanisms. Most notable is the inherent bias in the Medicaid program for institutional (nursing facility) care. This bias exists because nursing facility care is an entitlement, while home- and community-based services are not. Ironically, accessing the type of care and services that elders and younger adults with physical disabilities most desire, i.e. home- and community-based services that allow them to live independently, requires many individuals to get on a waiting list and hope that a waiver slot opens up soon. At the same time, the service and setting they least covet (a bed in a nursing facility) is readily available. This is the very dilemma that Vermont seeks to address.

Medicaid is the single largest funding source for long-term care in the State of Vermont and the nation. Accordingly, the reimbursement policies of that program have a tremendous impact on the availability of resources and the utilization of services. For years, the institutional bias of the program has driven supply and demand for nursing facility services, with HCB services largely relegated to relatively small waiver initiatives.

Under this demonstration Vermont will seek to change that dynamic by creating a program without institutional bias - financial or otherwise. It is specifically designed to help elders and younger adults with physical disabilities to live as independently as possible for as long as possible, in the settings of their choice.

Eligibility for the program will be similar in some respects to the eligibility requirements of typical 1915(c) Home- and Community-Based Services waivers in effect throughout the nation.

That is, eligible individuals must be residents of the State who are age 65 years or older, or those age 18 and older whose primary needs are the result of a physical disability. The program will have three eligibility levels; Highest Need, High Need and Moderate Need.

The “Highest Need” group will be entitled to either nursing facility or home- and community-based care. This entitlement to either setting represents a dramatic change in how long-term care services are provided in Vermont. Today approximately 2,200 individuals are benefiting from the entitlement to nursing facility care. Under this change in entitlement, Vermont projects that nearly 3,000 individuals will benefit from the broader entitlement to both nursing facility and HCBS by allowing the additional 800 individuals equal access to either category of service. All Demonstration participants in the Highest Need group must meet the financial eligibility criteria for Vermont Long-Term Care Medicaid.⁴ Vermont anticipates that given equal access to either nursing facility or home-based care, more individuals will choose home-and community-based care. This will allow the State to serve more individuals for the same amount of money.

Vermont also proposes to create two “expansion groups” of waiver eligibles in the hope of serving more individuals than are currently being served.

The first expansion group will be created by slightly modifying current nursing facility and HCBS Waiver eligibility clinical criteria. Individuals meeting the revised clinical criteria will constitute the “High Needs” group. Members of this group will not be legally “entitled” to long-term care services, but will be served to the extent that funds are available. These individuals must also meet the existing long-term care financial Medicaid eligibility criteria⁵ and the revised clinical standards for the Demonstration. Given historical utilization, the State expects that this group will consist of approximately 200-300 individuals each year. Vermont fully expects that the individuals in this subgroup will all be served under the waiver; however, there is the remote possibility that they would not be served if no funds were left after serving the Highest Need group. These individuals would still be eligible for the many home- and community-based and Medicaid State Plan services that would continue outside this Demonstration.

⁴ The one exception is with respect to resources. Demonstration participants electing home-based services may retain up to \$10,000 in resources.

⁵ Ibid 4

The second expansion group will include individuals who do not meet current nursing facility or HCBS Waiver eligibility criteria or the clinical criteria for the High Need group, but are believed to be at risk of institutional placement based on their assessed care needs. Vermont believes that if services can be provided to these individuals earlier than the current practices allow, their care. These individuals will be assessed and provided with only those services (not covered by other funding sources) necessary to help maintain their well being and independence. This might be as as a weekly homemaker visit, or a monthly case management visit. This group will be called the conditions can be stabilized or improved, thus avoiding or delaying more costly institutional little “Moderate Needs Group”. Individuals in this group will be served to the extent funds are available after serving all eligibles in the Highest and High Need groups. Vermont will designate some funds in the beginning of the Demonstration to ensure at least the provision of case management services for individuals in this group. The State will also include funds to make some Homemaker and Adult Day services available to this group. Details on the eligibility rules and enrollment procedures are discussed in Chapter 2 of this document.

Demonstration Design

The Demonstration is designed to maximize choice for consumers who need long-term care by creating equal access to nursing facility and home- and community-based services for all Medicaid long-term care recipients. The hypotheses is that when equal access to services exists, more individuals will choose home- and community-based services, thereby freeing up funds to provide preventive services to eligible individuals with somewhat lesser needs in the hope of delaying or preventing the necessity of institutional care.

The proposed Long-Term Care Demonstration program is comprised of a series of key components. Each component provides a critical building block for constructing a comprehensive, consumer-centered long-term care system. Each component contributes not only to the integrity of the overall system but to its fiscal soundness and sustainability as well.

Each of the nine components is described below. State staff executes some of the components, while others are carried out on the State’s behalf by local organizations. The first component – the Statewide Educational Initiative – is a centerpiece of the overall program. From there the

program flows through a process of referral intake and preliminary assessment, enrollment in the Demonstration (if eligible), a thorough evaluation of clinical and social support needs, the development of a comprehensive care plan and the associated budget for its execution, and an ongoing process of monitoring and updating the plan based on changes in an individual's needs and circumstances.

Program Components

Statewide Educational Initiative

A series of educational programs will be directed at providing individuals and their families with complete, unbiased information on the range and type of long-term care services available in the community, and the funding sources and eligibility criteria for government-sponsored programs. The Vermont Department of Aging and Disabilities will employ various media to provide outreach and education statewide with respect to the long-term care demonstration program. These broad-based initiatives will be specifically designed to ensure the dissemination of information throughout the state, and will not necessarily be targeted just to Medicaid eligible individuals. The participation and support of private practice physicians and other health care professionals will also be sought. DA&D intends to do extensive outreach with physicians and other health care professionals in the community to educate them about the Demonstration and to encourage referrals of patients with long-term care needs to the program.

Individuals will be informed about the long-term care services covered under the waiver for Demonstration participants. Potentially eligible persons will be informed that nursing facility care is covered under the Demonstration only if such care is medically necessary, given the individual's condition and circumstances. If an individual becomes eligible to participate in the Demonstration during the course of a stay in a nursing facility and an independent evaluation indicates that the nursing facility level of care is not medically necessary, the cost of the nursing facility will not be reimbursed by Medicaid under the Demonstration, unless no other appropriate placement is available. In such cases, discharge planning will continue.

Referral Intake and Preliminary Assessment Process

This process will occur at the time the individual is identified as potentially requiring long-term care services. Referrals for preliminary assessments can come from a variety of sources including self-referrals, family members and friends, physicians, community agencies, hospitals, or other providers. Individuals do not have to be eligible for the Demonstration to receive assessment services.

During the assessment process, persons are screened for potential eligibility for the Demonstration by DA&D staff. Those individuals who are not eligible for the Demonstration will be referred to the appropriate local agencies for further assistance in locating community-based resources.

All persons being discharged directly to nursing facilities from hospitals within the State of Vermont will be assessed in the nursing facility, if they convert from Medicare or Private Pay to Medicaid as their source of payment. Individuals who have Medicaid as a payment source at the time of admission will be assessed either before or shortly after admission. State staff will make every effort to assess Medicaid eligible persons prior to discharge from a hospital, but assessment will not delay appropriate discharge. During that assessment, nursing facility residents and families will be informed about the Long-Term Care Demonstration program, its eligibility criteria, and the covered benefits and services it provides. As part of its Utilization Review function, Vermont will continue to conduct intermittent evaluations, during the nursing facility stay to assess a resident's ability to opt for home- and community-based care.

If the individual opts for home- and community-based services, a certified case manager will assist the individual in making the transition from the nursing facility to the home or other alternative residential setting.

Enrollment into the Demonstration

Elders and younger adults with physical disabilities who meet the clinical and financial eligibility criteria will be enrolled in the Demonstration. The State will initially raise the limit on

resources from \$2,000 to \$10,000 for enrollees electing home-based services. Persons with resources above \$2,000 will be responsible for copayments for their services as described later in this Chapter. The retention of a higher level of monetary assets will address the concerns of many elders and younger adults with physical disabilities who continue to maintain themselves in the community and periodically need to expend cash assets to maintain their home. Those who have these concerns have identified a very low level of resources (\$2,000) as a barrier to accessing the Demonstration. Vermont believes that considering its overall objectives for this Demonstration, a \$10,000 resource limit is more appropriate for persons opting for home-based services. The \$10,000 limit seems reasonable when taking into consideration certain home maintenance costs, i.e. roofing, furnaces, hot waters heaters and other essential items. Enrollees who require nursing facility care or Enhanced Residential Care services must continue to spend down their resources to the current \$2,000 level before becoming eligible for Medicaid coverage. Knowing that the functional status of individuals might improve while they are in the nursing facility and that individuals frequently move between nursing facility care and home-and community-based care, Vermont is researching the possibility of protecting an individual's assets (up to \$10,000) for up to a 30-day stay in a nursing facility. This would allow the individual to have the necessary resources to return to the community if s/he is able.

In addition to raising the limit on resources for individuals enrolling in home-based services, Vermont will implement Presumptive Eligibility for Demonstration enrollees. After receiving a referral, DA&D staff will conduct an assessment of both the individual's clinical and functional status, as well as his/her financial circumstances. DA&D staff will determine clinical eligibility at that point. Based on information provided about the individual's financial situation, DA&D staff may deem the individual presumptively eligible. This will enable the consumer to receive needed services while the final eligibility determination is being made by PATH. Presumptively eligible enrollees who mislead or misinform DA&D with respect to their financial situation will be held liable for the cost of any services provided during the presumptive period. Based on historical experience, DA&D expects very few instances where persons found presumptively eligible are ultimately determined to be ineligible.

Once it is determined that the individual is eligible to enroll in the Demonstration, a DA&D staff member will conduct an initial assessment of his/her clinical and social support needs. This

initial assessment will drive the determination of clinical need and the development of the initial Care Plan. DA&D staff will also determine if the enrollee is to be included in the Demonstration's Highest Need group. Highest Need group members include those individuals who are determined to be in need of extensive or total assistance with ADLs, have complex medical needs and need daily nursing care. Individuals who do not meet these criteria will be enrolled as members of one of the Demonstration's Expansion groups (High Need or Moderate Need), depending on the results of their clinical assessments.

Once an individual is enrolled in the Demonstration as a member of the Highest Need group, he/she will receive all necessary covered long-term care services through the 1115 waiver program. This Demonstration program will not affect eligibility for Medicaid-covered State Plan services.

Individuals enrolled in the Demonstration as members of the High and Moderate Need groups will receive long-term care services only in the amount that can be financed under the waiver. This may include a partial service plan under the Demonstration coupled with other services available in the community outside of the waiver, including, home health services covered by Medicare or the Medicaid State Plan, dementia respite grants, senior center services, Older Americans Act services such as congregate meals, home-delivered meals and case management, and the DA&D Housing and Supportive Services program.

Evaluation of Individual Enrollee Clinical and Social Support Needs

As described above, once the DA&D staff determines that the individual meets the criteria for the Highest Need Group, the individual is assisted in making the choice of nursing facility or home- and community-based care. If nursing facility care is chosen, DA&D will forward the initial assessment and notice of presumptive eligibility to the facility and to the Department of Prevention, Assistance, Transition and Health Access (PATH).

If the individual chooses care in a home- or community-based setting, the enrollee will be asked to select a case management agency (one of 12 regional home health agencies or one of five Area Agencies on Aging.) The certified case manager from the selected agency will then

complete a comprehensive assessment using the DA&D Independent Living Assessment Tool (Appendix A). The evaluation includes an assessment of the person's physical and mental status, his/her social support system, living arrangements, need for assistance with activities of daily living and instrumental activities of daily living.

Development of Individual Comprehensive Care Plans for each Enrollee

Once the certified case management completes the comprehensive assessment, an individualized care plan will be developed. DA&D staff will review these plans. The assessment and plan of care will be updated at least annually for those enrolled in the Demonstration and more often if warranted by changes in the enrollee's situation or condition. Any subsequent changes in care plans will also be submitted to DA&D staff for approval. The enrollee is considered to be an active participant in the care planning process and will be notified of any modifications to his/her plan. Enrollees who wish to appeal a modification (reduction) in services may do so according to existing Medicaid appeal procedures.

The care plan includes an array of services based on the need determined using data from the comprehensive assessment, and the individual's status as a Highest Need, High Need or Moderate Need enrollee. Case management services, personal care or attendant services, respite care, enhanced residential care, assisted living and nursing facility services, adult day health care services, assistive devices and home modifications, companion services, and personal emergency response systems may be included in the care plan. The plan will also include informal supports, other appropriate Medicaid State Plan services and home- and community-based services. The plan will specify not only the services to be provided, but also the quantity in which they are to be provided and the provider designated to deliver each service.

Individuals in the High and Moderate Need groups who are not currently receiving services due to a shortage of available funds under the Demonstration will still be eligible for other non-Medicaid services available in the community, Medicaid State Plan Services and Medicare services. All Demonstration enrollees, including those in the Expansion Groups – High Need and Moderate Need groups - (if they are eligible for Community Medicaid) will be eligible for case management services. Those enrollees who are being served, but perhaps not to the full

extent of their needs, will also be directed to other community-based resources. Appendix D to this document lists the services available outside of the Demonstration Waiver.

Enrollees and/or their designees will be encouraged to participate in the care plan development process. The enrollee and his/her designee will also sign off on the care plan, indicating acceptance of the services contained therein.

The Department of Aging and Disabilities will audit the care plan development process to ensure its integrity. DA&D will also monitor, directly or indirectly, the delivery of services under the care plans and will track the proportion of services included in the plan that are actually delivered to the enrollee.

Nursing facility services will be included in the care plan if the individual meets the clinical eligibility criteria and the individual or his/her legal representative has chosen this long-term care setting. Health and welfare issues are central to any decision with respect to the need for nursing facility care, and will be considered as part of the assessment process.

Only those services included in an enrollee's comprehensive care plan are reimbursable by Medicaid under this demonstration. There will be no reimbursement for "off-plan" services. The cost of any long-term care service provided outside the plan of care is the financial responsibility of the enrollee. Some substitution of services will be allowed for those in the Cash and Counseling pilot, but each individual service must be listed in the comprehensive care plan. Acute care services and services rendered on an emergency basis are covered in accordance with the provisions of the Vermont State Medicaid Plan. The comprehensive care plan will also include a back-up care plan in the event of an emergency.

Development of a "Cash and Counseling" Pilot

Vermont will develop a pilot, initially in one or two counties, to test the efficacy of a "Cash and Counseling" Program. Individuals will be assisted by certified case managers in the development of a comprehensive care plan and budget to support that plan. Certified case managers will help determine the appropriateness of this option for an individual, based on

his/her assessment and other screening tools developed for this purpose. The certified case manager will provide counseling and support to consumers who have elected and been approved to participate in the pilot. A workgroup, with many consumer members, has been convened to help design the details of the pilot using information gleaned from the results of the three Robert Wood Johnson Foundation pilot states.

All other Demonstration enrollees will receive assistance from their case managers in arranging for the services called for in the care plan.

DA&D expects that by Year 2 of the demonstration these pilot programs will expand significantly with large-scale consumer-directed initiatives operating throughout the State.

Ongoing Monitoring and Modification of the Care Plan and Corresponding Budget

For individuals residing at home or in an adult foster family care home (a residential alternative under development by DA&D), certified case managers will meet, face-to-face, with each Demonstration enrollee at least monthly. During these meetings, case managers will conduct informal assessments of the enrollee's ability to be maintained in the community given his/her current level of support. They will monitor for any change in the enrollee's condition that would necessitate a formal re-assessment of the enrollee. They will also identify any service delivery issues, or new problems that have not been addressed.

Periodic, formal reassessments are conducted of each individual enrolled in home- and community-based services to ensure that the services being provided are adequate and appropriate. Reassessments will be conducted at least annually and more often if there is a significant change in the individual's status. Enrollees residing in nursing facilities, Enhanced Residential Care Homes and assisted living residences will also be periodically reassessed according to existing regulations, using the existing assessment tools. For nursing facilities, this is the MDS. For Enhanced Residential Care Homes and assisted living residences, Vermont uses an MDS-like assessment tool (see Appendix E). As the individual's circumstances change over time, reassessments will be completed, care plans will be modified and new budgets will be developed.

Vermont will continue to ensure the health and welfare of each enrollee. Demonstration enrollees who might not otherwise appear eligible for nursing home care, but who, due to emergency circumstances, require that setting for their health and welfare, will receive nursing facility care, at least temporarily. Emergency admission is defined as a situation in which an individual is likely to experience death or serious and permanent harm unless admitted to a nursing facility, or when admission to the facility was from a hospital emergency room.

Also, if an individual is admitted to a nursing home, and then improves and is no longer eligible for that setting, but for whom no safe alternative can be found, then she/he may remain in the nursing facility until a safe setting for discharge can be arranged. This is the current practice in Vermont, although it is rarely invoked.

Quality Monitoring and Management Program

Vermont's Department of Aging and Disabilities has developed a comprehensive program for monitoring the level and quality of services provided to Demonstration enrollees, which will be expanded under this proposal. Chapter 4 of this proposal describes those initiatives.

Long-Term Care Ombudsman Program

Vermont will expand its current Long-Term Care Ombudsmen program to make it a true long-term care program covering the full range of services provided under the Demonstration, not just nursing facilities and enhanced residential care homes. The Ombudsmen will be available to receive and investigate complaints regarding services rendered under the Demonstration, providing third party oversight of the program. They will also serve as consumer advocates.

Encourage Early Planning and the Purchase of Private Long-Term Care Insurance

Vermont will evaluate ways to encourage individuals to purchase long-term care insurance as a way to help reduce the burden on the State and Federal budgets. It will explore financial incentives such as State tax credits or income deductions. Vermont is in the process of

completing the development of its long-term care insurance regulations. DA&D will work with the long-term care insurance industry, the Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA), and other interested parties to research methods to encourage the purchase of long-term care insurance. Vermont will also develop a public information initiative to inform consumers about long-term care insurance.

Program Administration

The Department of Aging and Disabilities (DA&D) will serve as a capitated long-term care managed care plan under this waiver. The Agency for Human Services, the single state agency for Medicaid, will provide a global budget to DA&D, which will be determined based on the historical per-member-per-month fee-for-service equivalent cost of the current long-term care program times the total number of enrollees expected under the Demonstration. This will ensure that the Agency assumes responsibility for the cost of services to individual enrollees, and the number of persons served under the waiver.

In order to ensure appropriate management of costs, DA&D will provide oversight of the development of the comprehensive care plans developed for each enrollee by the certified case managers and provide technical assistance as needed. Projected expenditures will be continuously monitored based on the budgeted cost of each care plan. DA&D will use its Services, Accounting and Management System (SAMS) and DAILCare databases in concert with the EDS claims payment system to track program financials and budgets.

The actual claims cost for services provided under the Demonstration will be continuously compared with the projected expenditures under the aggregate budgeted cost of all care plans for enrollees. These comparisons will be reported by DA&D to the Office of Vermont Health Access on a quarterly basis. When actual expenditures exceed the projected care plan-based aggregate budget by more than two percent (annualized) in any given month, a Corrective Action Plan will be developed and implemented by DA&D.

DA&D will reserve a portion of the program funds upfront to provide case management and a limited range of preventive services for the High and Moderate Need groups. Once savings

begin to accumulate under the Demonstration, DA&D will use some of those funds to further expand services to these two groups under the Demonstration. This will include persons who do not meet the State Plan eligibility criteria for the Medically Needy program and are not SSI-eligible. Once service delivery to the High and Moderate Need groups begins, DA&D will be at risk for the cost of these enrollees to the extent that total costs exceed the Federal budget neutrality limit.

The expansion of services to the High and Moderate Need groups will be done incrementally to ensure that the program can be sustained. Populations targeted for enrollment in the Moderate group will include persons who do not currently require HCB services to remain in the community, but who are at risk of reaching that stage within 12-24 months if some level of intervention does not occur. Determination of who is at-risk will be made through the application of the State's initial assessment. Individuals in the High Need group will be served before allocating dollars to services for the Moderate Need group (other than for case management and a limited range of preventive services). Mechanisms will be developed to prioritize individuals within each group to ensure that services are provided first to those most in need.

A portion of the savings achieved under the Demonstration will also be used to increase the breadth and volume of services available in underserved communities. For instance, DA&D may seek to increase reimbursement for residential care homes/assisted living residences to entice new providers into the market and encourage existing providers to expand capacity. Similarly, DA&D will consider providing grants to expand adult day health center capacity. In that event, DA&D will be the grantor. It will also consider ways to expand programs to prevent caregiver "burn-out" (e.g. the Dementia Respite Program). This program provides caregivers with the financial resources to take "time-out" from the day-to-day responsibility of caring for certain Demonstration enrollees, particularly persons with dementia.

Demonstration Enrollee Cost Sharing

Demonstration enrollees will be subject to modest cost sharing. There will be copays for certain HCB services. Copays will be tiered based on the enrollee's income.

Income above the 300 percent SSI level will disqualify the individual financially, although individuals who meet the clinical criteria for the Highest and High Need groups may spend down to that level to qualify for services under the Demonstration. In the Highest and High Need groups, individuals will be subject to the Long-Term Care Medicaid patient share provisions of the existing Medicaid program. Individuals in the Moderate Needs group must spend down excess income in accordance with the methods use for the State's medically needy program prior to being found eligible for the Demonstration.

Individuals otherwise eligible for the Demonstration, but who have resources between \$2,001 and \$10,000 will be enrolled in the program, but will only receive home- based services; not Enhanced Residential Care or adult family foster care (should DA&D develop that residential option). These enrollees with resources between \$2,001 and \$10,000 will be required to make copayments for services in recognition of their additional monetary assets. Vermont is considering copayments in the range of \$50-\$100 per month, depending on the actual resources determined during the eligibility process. Copayment levels will be adjusted annually at recertification based on the individual's financial circumstances at that time. Individuals will be required to report the acquisition of any new financial resources, which would result in their total resources exceeding \$10,000. Individuals with resources between \$2,000 and \$10,000 who move from home-based care to an institutional setting (including Enhanced Residential Care Homes), must spend down their excess resources before the institutional care can be paid for under the Demonstration.

Chapter 2: Eligibility and Enrollment

Financial eligibility criteria for the Demonstration will be the same as for the current Medicaid Long-Term Care program, except that a higher level of resources will be permitted for enrollees who elect home-based care. The Caseload Estimates presented in Chapter 5 project months of eligibility based on historical trends in Medically Needy, SSI and Blind/Disabled adult populations in the program. Three Medicaid Eligibility Groups (MEGS) are presented: Highest Need; High Need; and Moderate Need. The Cost Estimates also include the historical per recipient per month costs.

The State will serve members of the Highest Need group on an entitled basis. These individuals must be found eligible for long-term care Medicaid under all existing eligibility criteria – clinical and financial, including restrictions on transfer of assets. These individuals will be allowed to spend-down excess income and resources to meet the financial eligibility requirements. They will also be permitted to retain up to \$10,000 in resources if they elect to be served at home.

The State will also sponsor an expansion eligibility category referred to as the High Need group. The High Need group will include individuals who meet the current long-term care financial eligibility requirements, but not necessarily the existing clinical long-term care requirements. They must, however, meet the clinical requirements for the High Need group under this Demonstration. These individuals will be allowed to spend-down excess income and resources to meet the eligibility requirements. However, the individuals in this group are not legally entitled to services under the Demonstration. Individuals in the High Need group are also permitted to have up to \$10,000 in resources if they elect home-based care.

Finally, the State will sponsor a second expansion eligibility category known as the Moderate Needs group. The income and resource requirements are the same as those for the Highest and High Needs groups; however, no spend-downs will be allowed. The individuals in this group will have to meet the clinical criteria for the Moderate group; however those criteria will be less intense than the criteria for the other groups. These individuals will not have a legal entitlement to Long-Term Care services.

They will receive services only to the extent that funding is available. Their eligibility will be determined using a streamlined application form with self-declared income and resources.

The following table depicts the eligibility groups under the Demonstration.

Waiver Medicaid Eligibility Group (MEG)	Highest Need Group	High Need Group	Moderate Need Group
Physically disabled adults meeting current Medicaid LTC eligibility standards	√	√	
Physically disabled adults who do not meet current Medicaid LTC clinical eligibility standards but meet the Demonstration Clinical Criteria and the financial criteria for LTC Medicaid			√
Medically Needy adults who meet current LTC eligibility standards	√	√	
Medically Needy adults who do not meet current LTC eligibility standard but meet the Demonstration Clinical Criteria and the financial criteria for LTC Medicaid			√
Dual Eligibles who meet current LTC eligibility criteria	√	√	
Dual Eligibles who do not meet current LTC eligibility criteria but who meet the Demonstration Clinical criteria and the financial criteria for LTC Medicaid			√

NOTE: Current Medicaid LTC eligibility standards refers to those eligibility criteria in place prior to the implementation of this LTC Demonstration Project.

Table 2 below summarizes the financial eligibility criteria and benefit coverage. Chapter 3 contains the details with respect to covered services and the service delivery system.

Table 2

Demonstration Eligibles	Highest Need	High Need	Moderate Need
Income	300% of SSI	300% of SSI	300% of SSI
Resources	\$2000/\$10,000 ⁶	\$2000/\$10,000 ⁷	\$2000/\$10,000 ⁸
Benefit Coverage ⁹	All LTC Services (entitled to all medically necessary and appropriate services covered under the Waiver)	LTC Services based on available funding	LTC Services based on available funding ¹⁰

To the extent that the Demonstration produces savings, these funds will be used to expand the amount and array of services available to these groups. As savings accumulate further, the State may also further expand the eligibility criteria to allow more Vermonters to participate.

Individuals enrolled in this Long-Term Care Demonstration Waiver program will include all elderly persons (age 65 years and older) and adults with physical disabilities aged 18 years and older, who have been identified as needing long-term care services and who meet the Medicaid financial eligibility criteria under the waiver.

⁶ \$2,000 for individuals electing nursing facility or other residential level of care; \$10,000 for individuals electing home-based care.

⁷ Ibid 6

⁸ Ibid 6

⁹ If the Demonstration enrollee also meets the eligibility criteria for the Community Medicaid Program, she/he will also be eligible for all State Plan Medicaid services.

¹⁰ All enrollees will receive case management services.

No one under age 18 years will be enrolled in this program, but physically disabled children may be transitioned in from other programs serving children in the State of Vermont upon reaching adulthood. Individuals under age 18 will continue to be eligible for appropriate State Plan services.

Persons eligible for Medicaid and receiving long-term care services on the start date of this waiver will become enrolled in the Demonstration, including any recipients enrolled in existing Aged and Disabled 1915(c) waiver programs, which will be subsumed by the Section 1115 waiver. The result is to essentially “grandfather” in the population currently served in nursing facilities or through the Aged and Disabled 1915(c) waivers. Individuals in other 1915 (c) waivers operated by the State are not included in this Demonstration.

Individuals screened out through the PASARR will not be enrolled in the Demonstration, nor will PACE enrollees. Vermont has also submitted a proposal to CMS for the “Vermont Independence Project - VIP”, which asks for Medicare reimbursement for case management services to assist individuals to manage their chronic disease. If this program is ultimately approved, the Medicare funds associated with case management services for the approved population will be rolled into this waiver.

Individuals residing in nursing facilities on a permanent basis, and whose assessment indicates that nursing facility care is the only safe and appropriate long-term care alternative, will be enrolled in the Demonstration. Individuals in this population will continue to be evaluated using the MDS unless their status changes and discharge from the nursing home is determined to be feasible. At that time they will be reassessed using the Independent Living Assessment.

New applicants will have a clinical assessment to determine potential eligibility for the Demonstration and the appropriate category of need – Highest, High or Moderate. They will also be screened in terms of financial eligibility. If the applicant meets the clinical criteria for the Highest Need group and, based on self-declared income and resource information, appears to meet the financial criteria, she/he will be presumptively enrolled so that services can begin immediately. The Department of Prevention, Assistance, Transition and Health Access (PATH) will make the financial eligibility determinations for all Demonstration enrollees. If the

presumptive eligibility process proves successful, it will be expanded to include individuals entering the High Needs group as well.

Once enrolled in the Demonstration, individuals must select a case management agency (either a regional home health agency or an Area Agency on Aging). All case managers must be certified by DA&D. There are extensive requirements with respect to education and/or experience. These are detailed later in the proposal. These requirements are identical to those approved by CMS in Vermont's current 1915 (c) waiver. The case manager will be responsible for the development, monitoring and updating of the enrollee's comprehensive care plan. The case manager will work collaboratively with the Enrollee and/or his/her designee on the development of the care plan. This collaborative effort can include spouses and other family members, guardians, friends and supportive caregivers.

Any Medicaid-eligible applicant who is denied enrollment in the Demonstration may appeal that denial according to existing Medicaid appeal procedures.

Consumers may enter appeals on clinical determinations (whether or not an individual is eligible or ineligible and also decisions about level of clinical need, i.e. appropriate LTC Program group), determination of financial eligibility, services authorized in the Plan of Care and how the person was evaluated in the prioritization process used for individuals waiting for services in the High and Moderate groups.

Chapter 3: Covered Services and Delivery Model in the Demonstration

Under the Demonstration there will be two types of services – Core and Optional. Core services will be available at all times, based on clinical needs, to Demonstration enrollees in the Highest Need group. Core services will also be available to the High and Moderate Need groups to the extent funding is available. Optional Services will be added to the Demonstration for all groups as funding becomes available.

Scope of Covered Services

Demonstration enrollees will be eligible to receive all covered long-term care services through this waiver program. Medicaid State Plan services will be provided as they are today. Services will be covered, based on their inclusion in an approved comprehensive care plan, at the level called for in that plan. The following is a description of the core services that may be included in a comprehensive care plan, based on the needs of the individual enrollee:

Core Services

Personal Care Services – There are two types of Personal Care Service providers; both types of providers render assistance with Activities of Daily Living (ADLs) like eating, dressing, walking, transferring, toileting and bathing. Instrumental Activities of Daily Living (IADLs) such as cooking, cleaning, and shopping assistance may also be provided. Services may be provided by regional home health agencies or by attendants hired, trained, and supervised by qualified consumers or surrogates. This option is currently available under DA&D's 1915(c) Waiver. In some cases, these services are also currently being provided by relative caregivers, with the exception of spouses and individuals under the age of 18. This Demonstration will expand the use of relative caregivers on a compensated basis to include personal care services provided by a spouse. The State will make the determination as to whether the spouse is able to provide the personal care services included in the enrollee's care plan and is also the best provider to do so. DA&D will develop screening criteria, which will be used to evaluate requests for spousal caregiver services on a compensated basis. DA&D has administered an Attendant Services Program that uses this method of care delivery for more than 20 years.

Respite Care – Respite care may be provided in home settings, adult day centers, residential care homes or in nursing facilities to relieve primary caregivers.

Companion Services – This includes non-medical care, supervision, and socialization provided to a functionally impaired adult. Companions may assist or supervise with tasks such as meal preparation, laundry, and shopping, but these tasks are not performed as a discrete service. This service does not entail hands-on personal care. Companions may perform light housekeeping tasks, which are incidental to the care and supervision of the individual. Individuals providing this service must be high school graduates or the equivalent, 18 years of age or older and have training and skills that are specific and adequate to meet the needs of the individual participant. These qualifications are identical to those that were approved by CMS for Vermont's current 1915(c) waiver.

Adult Day Services – These are community-based non-residential services designed to assist impaired or isolated adults to remain as active in their communities as possible, maximizing their level of health and independence and ensuring the optimal functioning of the participant. Services include a range of health and social services for participants and provide respite for primary caregivers. Services are furnished for a specified number of hours per day on a regularly scheduled basis, for one or more days per week.

Personal Emergency Response Systems – These include electronic devices, which enable individuals at high risk to secure help in an emergency.

Assistive Devices and Home Modifications – Assistive Devices are any items used to increase, maintain or improve functional capabilities and independence in performing ADLs or IADLs. Home modifications include any physical adaptations to the home which are necessary to ensure health and welfare of the individual and which maintain, increase or improve functional capabilities and independence. This may include ramps, door widening, grab-bars and modification of bathroom facilities, etc., but not repairs, maintenance or new construction. Physical adaptations included in the enrollees comprehensive care plan are reimbursable up to \$750 per calendar year. The State is reevaluating the per person amount allowed for this benefit.

Also included are electronic monitoring or tracking devices, which are necessary to ensure the health, welfare and safety of individuals with moderate to severe dementia or comparable cognitive impairment.

Nursing Facility Services – Care in a licensed nursing facility.

Enhanced Residential Care Home/Assisted Living Residences Services – A bundled package of services provided by an approved Level III Residential Care Home (RCH) or Assisted Living Residence (ALR). In addition to services provided to all RCH/ALR residents, these residential settings also provide a Registered Nurse on-site for a minimum of one hour/week per waiver participant, and an average of two hours of personal care services per waiver participant per day. Daily social and recreational activity opportunities are also provided.

Case Management Services – This includes assisting individuals in gaining access to needed waiver and other State Plan services as well as needed medical, social, educational and other services regardless of the funding source. The case manager is responsible for the ongoing monitoring of the provision of services included in the comprehensive care plan. The case manager performs necessary assessments and reassessments of the individual's needs and reviews plans of care at least annually or more often if needed to respond to changes in conditions or circumstances.

Homemaker Services – These include assistance with house cleaning, food preparation and clean up and shopping for individuals who do not otherwise require personal care services.

Optional Services

The following optional services will be added to the Demonstration as funding becomes available, subject to overall budget neutrality limitations:

Home Delivered Meals – This includes the provision of a meal(s) to the enrollee's residence, with each meal meeting 1/3 of the full daily nutritional regimen.

Other Living Arrangements – This includes support for alternative living arrangements such as activities in residential care or assisted living residences, and other appropriate supports for home sharing, Housing and Supportive Services (HASS) and adult foster family care.

Bed Hold/“Leave” Days – This includes payment for days (up to 10 days per episode) when the enrollee is away from the enhanced residential care home due to an acute inpatient admission.

Covered Service Limitations

The scope and quantity of services to be provided to an individual under the Demonstration will be clearly delineated in the enrollee’s comprehensive care plan. Only those services included in the care plan are reimbursable by Medicaid under the Demonstration. “Off-plan” services are the financial responsibility of the enrollee, if not funded by another payment source.

Enrollees may appeal any denial of, or reduction in, services in the comprehensive care plan following the existing Medicaid appeal procedures.

Approved Medicaid providers provide all long-term care services included in an enrollee’s care plan. Services are reimbursed on a fee-for-service basis, utilizing fee schedules approved by DA&D and the Office of Vermont Health Access (OVHA), the Medicaid Division of PATH. Regional home health agencies directly provide or arrange for the provision of many of the services included in the care plans. The five Area Agencies on Aging also provide waiver case management services and arrange for services provided in the care plans.

Vermont has chosen not to include the following Medicaid State Plan services in the 1115 Demonstration Waiver: (1) home health services including RN, physical therapy, occupational therapy, speech therapy, Licensed Nursing Assistant services, and social work; (2) Day Health Rehabilitative Services (DHRS); and (3) Assistive Community Care Services (ACCS). These services are targeted to individuals with more acute care and short-term rehabilitative needs.

DHRS services are delivered at adult day centers and are designed to provide rehabilitative services to frail elders and younger adults with physical disabilities.

Assistive Community Care Services are delivered in Level III licensed residential care homes and assisted living residences. The payment mechanism is complex and did not lend itself to inclusion in the Demonstration.

Vermont also intends to continue providing Licensed Nursing Assistant services outside of the waiver. These LNA services have historically been considered similar to Medicare LNA services, and are intermittent skilled services related to sub-acute and rehabilitative care, not on-going personal care.

Service Delivery and Financing Model

Medicaid approved and contracted fee-for-service providers and individuals under the consumer/surrogate directed options provide services included in an enrollee's comprehensive care plan. That system will remain in effect with this program. Claims will be submitted and reimbursed by the State's Fiscal Intermediary (EDS) in accordance with requirements and fee schedules in effect for the program. Individual providers or groups of providers will not be capitated or at-risk financially for the cost of care for any individual enrollee or group of enrollees.

In Vermont, many of the long-term care services will be provided by 12 regional home health agencies. Each home health agency serves a defined geographic region on a non-competitive basis. This model has been in place in Vermont for many years and has been shown to work best in an environment that is largely rural, and not conducive to competitively driven profit centers.

Other services will be provided by community-based entities such as small residential care homes and assisted living residences, Area Agencies on Aging, meals-on-wheels programs, Durable Medical Equipment vendors, home adaptation contractors, adult day centers, and individual attendants hired and supervised by Demonstration enrollees.

Nursing facilities will continue to be an important component of the service delivery system. Vermont's nursing facilities will provide institutional long-term care services to many Demonstration enrollees who choose and are eligible for this level of care. These facilities will continue to be reimbursed on a per diem basis at rates established by Division of Rate Setting.

Oversight, Monitoring and Reporting on Comprehensive Care Plans

In Vermont the regional home health agencies serve a dual role. First, these entities provide case management services and conduct updates and modifications to care plans. Second, they provide direct care services. To counter any bias in care plan development by organizations also charged with providing the services listed on the care plans, DA&D maintains a robust oversight, monitoring, and reporting function.

DA&D tracks the content of all care plans using its DAILCare database system. This system enables the department to compare and contrast the care plans developed by different agencies across like populations. It can examine differences between plans developed by area agencies on aging (which do not provide direct care services) and those developed by the home health agencies. The system also permits the department to closely monitor the quantity of services provided on a per enrollee and aggregate basis for each regional home health agency.

DA&D staff will review and approve all changes to plans of care. Where there are indications that the content of care plans of one or more agencies vary significantly from those of peer agencies serving similar populations, DA&D staff will evaluate the differences and determine if agencies are inappropriately ordering more or fewer services than appear necessary.

Additionally, DA&D has an ongoing monitoring and auditing function as a part of its utilization management program. DA&D UM staff will conduct site visits and review a sample of care plans quarterly. A uniform review tool will be used and results summarized and reported to each agency. Aggregate results will also be distributed to each home health agency and Area Agency on Aging.

As a part of its Quality Monitoring and Management (QMM) Program, DA&D clinical oversight staff review care plans to ensure that services on the plan are appropriate, both in scope and volume, relative to the identified needs of the individual enrollees. A random sample of ten percent of the cases from each of the 13 Waiver Team areas (with a minimum of five cases) will be reviewed annually. DA&D will use these findings and results as a part of its overall quality improvement activities. DA&D's proposed QMM program is further described in the next chapter.

Chapter 4: Quality Monitoring and Management Program

The Department of Aging and Disabilities will put in place a multi-faceted Quality Monitoring and Management (QMM) Program for the proposed Demonstration. The QMM program is reviewed in this Chapter and will be presented in more detail in the Operational Protocol for the Demonstration that will be subsequently submitted to CMS. The program is designed to ensure the highest possible level of quality of care and enrollee satisfaction with the long-term services provided under this Demonstration.

Consumer Satisfaction Survey

DA&D conducts an annual consumer satisfaction survey. This survey is based on a sample of recipients of home- and community-based care in the 1915(c) waivers and Attendant Services, Homemaker and Adult Day Programs. DA&D will continue to administer this survey under the Demonstration. To date survey results show high levels of consumer satisfaction with the care received. While it is acknowledged that consumer satisfaction alone does not necessarily ensure that the care was of high quality, it is an important indicator. A copy of the survey tool and the Executive Summary of the most recent completed survey are attached as Appendices F and G.

Review and Approval of all Plans of Care and Certification of Case Managers

The staff of the Department of Aging and Disabilities will review and approve all plans of care for Demonstration enrollees and any subsequent changes to those plans. This will ensure consistent approaches to care plan development and the allocation of resources. Additionally, all participants in the demonstration will have a designated case manager. The case managers must have a face-to-face visit with their assigned enrollees at least once a month and more frequently if necessary. Case managers are professionals who are certified by the State after the receipt of training and the passage of a comprehensive examination. Case managers who have been approved for certification must participate in a minimum of 20 hours of professional development education or training annually to maintain certification. Certification remains in effect unless revoked due to clear evidence that quality case management services, consistent with the DA&D Case Management Standards, are not being provided and/or professional

development and training has not been maintained. Where the Department has reason to believe that a case manager is not providing quality services, several actions occur. First DA&D will contact the agency case management supervisor and executive director to discuss the concerns and will proceed with an investigation. Second, the agency will evaluate the case manager's performance following DA&D written procedures. Based on the outcome of the agency's investigation, DA&D will make a determination regarding continued certification of the case manager.

When DA&D determines that it is necessary to revoke the certification of a case manager, that individual is prohibited from providing case management services unless the Commissioner grants him/her a provisional certification. A request for provisional certification must be submitted in writing within 30 days of the receipt of notification to revoke certification.

Tracking of Services Actually Provided

DA&D also monitors the quantity of services provided to enrollees versus those listed on the care plan. This ensures that the oversight agency knows what portion of the services included on the care plan were actually provided. For a variety of reasons, it is unlikely that 100 percent of the services listed would be provided, but a significant proportion should be delivered. In instances where a low proportion is observed by the State, DA&D staff will follow-up with the responsible agency to determine the reasons associated with the lack of service provision. A system for electronically tracking and trending this information for the Demonstration enrollees is being developed.

Local Waiver Teams

Under the Demonstration, as with the Vermont's current Home- and Community-Based Services waiver programs, local Waiver Teams will continue to provide significant oversight of the program. There are thirteen Waiver Teams throughout the State. These teams are comprised of representatives from the regional home health agencies, Area Agencies on Aging, adult day centers, local PATH offices, hospital discharge planners/social workers, residential care homes, assisted living residences and nursing facility social workers. Other providers such as the local

community mental health centers join the teams as needed. The teams meet monthly and review all active cases. Cases that involve outstanding issues are thoroughly discussed and alternative solutions or care approaches are reviewed. Under the demonstration, DA&D staff will facilitate the Waiver Teams, and provide technical assistance and updates about any changes in policies and procedures.

Oversight of Home Health Agencies/Residential Care Homes/Assisted Living Residences/Adult Day Centers

Much of the care provided to Demonstration enrollees will be provided by home health agencies around the state. These agencies are subject to state and federal regulations and are regularly surveyed by the DA&D Division of Licensing and Protection. These inspections include a review of the quality assurance and quality management activities and functions of the agency. DA&D also provides direct oversight of the residential care homes/assisted living residences in the State through its licensing and surveying responsibilities.

DA&D certifies all Adult Day Centers that receive state and/or federal funds as meeting the state standards. In addition, DA&D makes site certification visits to each Adult Day Center on at least an annual basis.

Checks and Balances in the Provider System

Many Demonstration enrollees receive services from multiple providers, including home health agencies, Area Agencies on Aging, adult day centers, respite service providers, transportation providers, and individual attendants. The involvement of multiple provider organizations helps to ensure a series of checks and balances in the system because all of these providers are mandated by law to report any actual or suspected abuse, neglect or exploitation. It also works to ensure that at least one provider will pick up on a situation that may be a precursor to future problems for the enrollee.

Other Quality Monitoring Activities

DA&D also conducts a variety of other monitoring activities to ensure quality of care. These include monitoring of grievances and appeals, nursing facility admission and re-admission rates to acute or long-term care facilities for Demonstration enrollees, DA&D interviews with consumers and changes in the functional status of enrollees based on their need for assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

The expansion of the Long-Term Care Ombudsman program to include home-based care will also add an important new element to monitoring efforts. Additional monitoring activities are performed through the complaint line staffed by the DA&D Division of Licensing and Protection and through investigations by Adult Protective Service investigators.

All of the initiatives and activities described in this chapter are undertaken in an effort to ensure that Demonstration enrollees are receiving the right services at the right level at the right time, and that those services are of the highest level of quality possible. Collectively DA&D's approach to identifying and addressing shortcomings revealed by its monitoring activities should result in continuous quality improvement in the long-term care system overall and for individual enrollees.

Chapter 5 Caseload and Cost Estimates

Overview

This chapter provides caseload and cost estimates for the Vermont long-term care population, under both the existing system and the proposed waiver program. The proposed 1115 waiver will cover long-term care services only; no acute services or dollars will be included.

The 1115 waiver estimates are provided using a template developed by CMS for the Pharmacy Plus demonstration initiative. This is an appropriate template for the Vermont Long-Term Care Plan because, as with Pharmacy Plus, Vermont's demonstration will use an aggregate, rather than per capita, budget neutrality test.

The remainder of this chapter provides supporting narrative for the caseload and cost exhibits produced using the CMS template. The CMS-formatted exhibits are contained at the end of the chapter (the original Excel files are also being submitted under separate cover). For reader ease, portions of the exhibits are reproduced in summary form in the body of the text. As both the exhibits and tables show, the Vermont Long-Term Care Plan is projected to cost no more than the existing program, even while expanding eligibility to frail elderly and physically disabled Vermonters currently receiving no services⁹.

Data Sources

The historical data presented in this chapter was extracted from Vermont's eligibility and claims payment systems and previously documented on the State's CMS-64 reports. The demographic and medical inflation trends applied to the historical data are an extrapolation of historical trends, with some adjustments to caseload based on expected growth rates among the elderly and adult disabled populations in Vermont, as described further below.

⁹ The expenditure, and associated eligibility expansion projections in this chapter assume sufficient State appropriations to secure the maximum available federal matching funds. The size of any future expansion will ultimately depend on the actual dollars appropriated.

Historical and Projected Caseload under the Existing System

Historical Caseload

The portion of the existing Vermont Medicaid population to be subsumed under the 1115 waiver consists of persons ages 18 and older who are residents of a nursing facility or enrolled into either the 1915(c) Home- and Community-Based Services (HCBS) waiver or Enhanced Residential Care (HCBS-ERC) waiver. All long-term care services for these three groups are currently reimbursed on a fee-for-service basis and will continue to be so under the waiver. Exhibit 5-A at the end of the chapter presents five years of detailed historical caseload data, starting with State Fiscal Year 1998 and running through State Fiscal Year 2002. All information is reported in terms of average caseloads and total eligible months. Table 5-1 below presents the same data in summary form.

5-1 Historical Long-Term Care Caseloads by Setting

Medicaid LTC Population by Placement	State Fiscal Year					Pct Change 1998 - 2002	
	1998	1999	2000	2001	2002	Average Annual	Total
Nursing Facility	2,366	2,349	2,287	2,156	2,180	-2.0%	-7.9%
HCBS	611	630	730	813	895	10.1%	46.5%
HCBS-ERC	<u>90</u>	<u>90</u>	<u>91</u>	<u>132</u>	<u>151</u>	<u>13.8%</u>	<u>67.8%</u>
Total	3,067	3,069	3,108	3,101	3,226	1.3%	5.2%

As the above table reflects, nursing facility caseload has been gradually declining in Vermont for many years, the result of existing State 1915(c) waivers designed to offer home- and community-based service options to persons in need of long-term care. During the period 1998-2002, total nursing facility eligible months fell by an average of two percent each year, or about eight percent for the entire period. In 1998, the average daily Medicaid census in Vermont's nursing facilities was 2,366; in 2002 it was 2,180.

Over these same five years, HCBS waiver member months grew at an annual rate in excess of ten percent, or more than 46 percent overall. Average enrollment increased from 611 in 1998 to

895 in 2002. HCBS-ERC member months followed a similar path, increasing by nearly 14 percent per year, or 68 percent overall. Average enrollment in the HCBS-ERC waiver grew from 90 to 151.

Long-term care caseloads across all three settings grew at an average annual rate of 1.3 percent during the five-year historical period. This rate of increase is expected to accelerate in coming years, for the reasons discussed below.

Projected Caseload

Historical caseload trends are an important component of projecting future caseload, but must be considered in the context of broader demographic trends. Two key determiners of future long-term care needs in Vermont (regardless of the system in place) will be the growth of the elderly population and changes in disability rates among adults, both those under age 65 and those 65 and older.

To more precisely understand the State's future long-term care needs, the Vermont Department of Aging and Disabilities in 2002 conducted a study of demographic trends for the period 2000 – 2010 in conjunction with the Lewin Group and the University of Massachusetts Institute for Social and Economic Research. Findings from the study were issued in May of this year¹⁰ and are summarized below.

The researchers relied on data from the 2000 Census and from the Current Population Survey to establish a population baseline for 2000 and projections through 2010. Disability trend rates for persons under age 65 were derived from Social Security Administration growth assumptions for

¹⁰ The full report entitled, "Shaping the Future of Long-Term Care – 2000 to 2010" is included as Appendix H to this application.

the number of workers receiving disability insurance benefits. Disability trend rates for persons age 65 and older were derived from Kenneth Manton's recent analysis of the 1999 National Long-Term Care Survey¹¹.

According to the study, Vermont's population as a whole is projected to increase eight percent from 2000 to 2010, while the State's elderly population (age 65 and older) is projected to grow by 18 percent and the age 85 and older cohort by 27 percent.

Table 5-2 below presents ten-year population trends, by age cohort, for the Vermont population. (Note that percentage trends are for the start of the waiver period through 2010).

5-2 Vermont Population Trends

Age	2000	2005	2006	2007	2008	2009	2010	Pct Change 2005 - 10	
								Average Annual	Total
Under 18	147,523	143,274	141,156	139,038	136,919	134,801	132,683	-1.5%	-7.4%
18 to 39	180,259	172,520	172,173	171,825	171,478	171,130	170,783	-0.2%	-1.0%
40 to 64	203,265	239,179	244,235	249,291	254,347	259,403	264,459	2.1%	10.6%
65 to 74	40,683	41,862	43,008	44,154	45,300	46,446	47,592	2.7%	13.7%
75 to 84	26,831	29,757	30,052	30,347	30,641	30,936	31,231	1.0%	5.0%
85+	9,996	11,283	11,568	11,853	12,138	12,423	12,708	2.5%	12.6%
TOTAL	608,557	637,875	642,191	646,507	650,824	655,140	659,456	0.7%	3.4%

The rapid growth in the number of aged Vermonters will be slightly offset by disability trends among the elderly. Recent national studies show a small drop off in the disability rate for persons age 65 and older, due to improvements in health, nutrition and medical treatments.¹² While these improvements may be less evident in the lower income population, the State estimates that the disability rate among elderly Vermonters will decline by about one percent each year through 2010.

There is an opposite trend line when looking at the population under age 65. Relying on national data, the State projects that the prevalence of disability among younger adults will climb by

¹¹ Manton, Kenneth F and Gu, XiLiang, Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population above Age 65 from 1982 – 1999. *Proceedings of the National Academy of Sciences*, Vol. 98, No. 11, 2001.

¹² Redfoot, Donald L and Pandya, Sheel M, Before the Boom: Trends in Long-Term Supportive Services for Older Americans with Disabilities. *AARP Public Policy Institute Issue Paper*, No 2002-15 (October 2002).

approximately three percent per year, primarily because medical advances are permitting more children with disabilities to survive into adulthood, and allowing adults with disabilities to live longer.

Taking all of these trends into consideration, the State projects that the number of adult Vermonters currently living at home or in the community who will require long-term care during the demonstration years will increase at an annual rate of 2.9 percent each year through 2010¹³. The number of low income Vermonters¹⁴ requiring such care will grow at an even faster annual rate of 3.6 percent (see Table 5-3 below).

This acceleration in the rate of increase from the historical pace is consistent with the expected rapid growth in the number of elderly Vermonters over the next five years, particularly the age 85 and older cohort.

5-3 Projected New Long-Term Care Need

	Calendar Year							Pct Change 2005 - 10		
	2000		2005	2006	2007	2008	2009	2010	Average Annual	Total
All Persons	3,424		4,538	4,670	4,801	4,867	5,064	5,196	2.9%	14.5%
Low Income	1,558		1,967	2,038	2,108	2,144	2,249	2,320	3.6%	17.9%

This reasonableness of this upward trend is also supported by the fact that, even with steady growth in HCBS enrollment during the past five years, Vermont has had a small but persistent waiting list of persons found eligible for the 1915(c) HCBS waiver but for whom no slots were available.

Historical and Projected Cost under the Existing System

Historical Cost

Like virtually every other state, Vermont has experienced a steady increase in per eligible costs for long-term care services over the past five years. Exhibit 5-A contains expenditure data for

¹³ The State defines this group as persons requiring assistance with two or more ADL's, excluding individuals with mental retardation or developmental disabilities. This is consistent with existing eligibility criteria for the 1915(c) waivers.

¹⁴ Defined as persons with incomes below 175 percent of FPL

the period 1998 – 2002, along with the caseload data previously discussed – both per eligible and aggregate.

Table 5-4 below presents summary information on average annual per eligible expenditures, by setting, during the five-year historical period. As it shows, the HCBS waiver in SFY 2002 was only 52 percent as costly as nursing facility placements, while the HCBS-ERC waiver was only 28 percent as costly. Although per capita expenditures have been increasing at a more rapid pace in the two 1915(c) programs than for nursing facilities, they remain far less costly on a per eligible basis.

5-4 Historical Long-Term Care Expenditures by Setting (Annual per Eligible)

Medicaid LTC Population by Placement	State Fiscal Year					Pct Change 1998 - 2002		HCBS as Pct of NF-2002
	1998	1999	2000	2001	2002	Average Annual	Total	
Nursing Facility	\$ 31,818	\$ 32,238	\$ 35,230	\$ 37,341	\$ 41,936	7.2%	31.8%	
HCBS	10,923	13,068	16,211	16,597	21,584	18.6%	97.6%	51.5%
HCBS-ERC	<u>6,550</u>	<u>8,575</u>	<u>11,268</u>	<u>9,242</u>	<u>11,724</u>	<u>15.7%</u>	<u>79.0%</u>	28.0%
Weighted Avg	\$ 28,226	\$ 28,812	\$ 31,401	\$ 32,488	\$ 36,586	7.8%	29.6%	

In terms of aggregate spending, the Vermont long-term care program has grown by \$30 million (state and federal) over the past five years, from less than \$83 million (state and federal) in SFY 1998 to nearly \$113 million in SFY 2002. Table 5-5 below presents summary data on aggregate expenditures.

5-5 Historical Long-Term Care Expenditures by Setting (Aggregate in 000's)

Medicaid LTC Population by Placement	State Fiscal Year (000's)					Five Year Total	Pct Change 1998 - 2002	
	1998	1999	2000	2001	2002		Average Annual	Total
Nursing Facility	\$ 75,281	\$ 75,727	\$ 80,570	\$ 80,508	\$ 91,421	\$ 403,507	5.0%	436.0%
HCBS	6,674	8,233	11,834	13,493	19,318	59,552	30.4%	792.3%
HCBS-ERC	<u>589</u>	<u>772</u>	<u>1,025</u>	<u>1,220</u>	<u>1,771</u>	<u>5,377</u>	<u>31.6%</u>	<u>812.9%</u>
Total	\$ 82,544	\$ 84,732	\$ 93,429	\$ 95,221	\$ 112,510	\$ 468,436	8.2%	467.5%

Projected Aggregate Costs Absent the Waiver

The appropriate trend factor for projecting aggregate costs is one that takes into account both caseload growth and medical inflation.

With respect to caseload growth, Vermont is projecting a 3.6 percent annual rate of increase across all settings, consistent with the Lewin Group/University of Massachusetts study findings. As shown in Table 5-6 below, the actual rate within the three program types will continue to differ, although the gap is expected to close slightly.

Absent the 1115 waiver, the State projects nursing facility days will stop declining and instead will grow at a modest rate of one percent per year as the number of frail and adults with disabilities continues to rise. The State projects that the two 1915(c) waiver programs will also continue to grow, but at a slightly reduced pace than that seen during the past five years. Without an 1115 waiver, HCBS waiver days are projected to increase at an annual rate of eight percent, down from ten percent; HCBS-ERC days are projected to increase at an annual rate of 11 percent, down from 13.8 percent.

With respect to cost, Vermont sees nothing in the historical data or broader national trends to suggest that the current medical inflation rate is likely to subside any time soon. The State therefore is projecting that the historical trend rates for each setting during the past five years will continue for the five-year demonstration period.

5-6 Proposed Caseload and Cost Trend Factors Absent the Waiver

Trend Period	Annual Caseload Change		Annual Cost Change	
	Historical	Waiver Period	Historical	Waiver Period
Nursing Facility	-2.0%	1.0%	7.2%	7.2%
HCBS	10.1%	8.0%	18.6%	18.6%
HCBS-ERC	13.8%	11.0%	15.7%	15.7%

Exhibit 5-B presents detailed annual and five-year expenditure projections under the current system, using the above “waiver period” trend factors. Table 5-7 below shows the same information in summary form.

5-7 Projected LTC Expenditures Absent the Waiver (Aggregate in 000’s)

	State Fiscal Year (000's)					Five Year Total
	2005	2006	2007	2008	2009	
Total LTC Expenditures	\$ 160,176	\$ 182,139	\$ 208,378	\$ 239,937	\$ 278,141	\$ 1,068,771

Projected Cost under the Waiver

As described in detail elsewhere in the proposal, Vermont intends to restructure its long-term care system so that, in the future, a larger portion of the population found eligible for long-term care may choose to be served in less costly home- and community-based settings rather than nursing facilities. The State is conservatively projecting that about nine percent of the adult Medicaid population that would have moved into nursing facilities during the demonstration years will instead elect to be served at home or in another community-based setting.

As shown in detail in Exhibits 5-C/5-D, and in summary form in Table 5-8, the State expects the shift toward greater use of home- and community-based services will reduce expenditures over the five years of the waiver, by approximately \$61 million (State and federal) versus what they would have been absent the waiver. Subject to appropriations from the Legislature, the State intends to use approximately 90 percent of the available \$61 million to serve individuals enrolled in the High Need and Moderate Need groups of the 1115 waiver, with the remaining ten percent left available for contingencies (again subject to appropriation of State matching funds).

5-8 Projected LTC Expenditures under the Waiver (Aggregate in 000's)

Total LTC Expenditures	State Fiscal Year (000's)					Five Year Total
	2005	2006	2007	2008	2009	
Without Waiver	\$ 160,176	\$ 182,139	\$ 208,378	\$ 239,937	\$ 278,141	\$ 1,068,771
With Waiver - Existing	\$ 150,906	\$ 171,480	\$ 196,165	\$ 225,985	\$ 262,246	\$ 1,006,782
With Waiver - Expansion	<u>\$ 9,960</u>	<u>\$ 10,558</u>	<u>\$ 11,191</u>	<u>\$ 11,863</u>	<u>\$ 12,574</u>	<u>\$ 56,146</u>
Difference (Without - With)	\$ (690)	\$ 101	\$ 1,022	\$ 2,089	\$ 3,321	\$ 5,843

As demonstrated through these caseload and cost tables, Vermont is confident that it will be able to extend services to persons in need who currently receive no assistance, while producing savings for both the State and federal governments.

EXHIBIT 5-A

HISTORIC DATA: BASE YEAR (BY) AND 4 PRIOR YEARS FOR CURRENT LAW POPULATIONS

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	BY-4	BY-3	BY-2	BY-1	SFY2002	5-YEARS
TOTAL EXPENDITURES						
Nursing Facility Residents	\$ 75,280,975	\$ 75,726,707	\$ 80,569,879	\$ 80,508,083	\$ 91,420,716	\$ 403,506,360
Average Census	2,366	2,349	2,287	2,156	2,180	
COST PER ELIGIBLE	\$ 31,818	\$ 32,238	\$ 35,230	\$ 37,341	\$ 41,936	
TREND RATES						5-YEAR AVERAGE
ANNUAL CHANGE						
TOTAL EXPENDITURE		0.59%	6.40%	-0.08%	13.55%	4.98%
ELIGIBLE MEMBER MONTHS		-0.72%	-2.64%	-5.73%	1.11%	-2.03%
COST PER ELIGIBLE		1.32%	9.28%	5.99%	12.30%	7.15%
TOTAL EXPENDITURES						
HCBS	\$ 6,673,912	\$ 8,232,901	\$ 11,833,772	\$ 13,493,438	\$ 19,317,629	\$ 59,551,652
ELIGIBLE MEMBER MONTHS	611	630	730	813	895	
COST PER ELIGIBLE	\$ 10,923	\$ 13,068	\$ 16,211	\$ 16,597	\$ 21,584	
TREND RATES						5-YEAR AVERAGE
ANNUAL CHANGE						
TOTAL EXPENDITURE		23.36%	43.74%	14.02%	43.16%	30.43%
ELIGIBLE MEMBER MONTHS		3.11%	15.87%	11.37%	10.09%	10.01%
COST PER ELIGIBLE		19.64%	24.05%	2.38%	30.05%	18.56%
TOTAL EXPENDITURES						
HCBS-ERC	\$ 589,483	\$ 771,737	\$ 1,025,352	\$ 1,219,894	\$ 1,770,393	\$ 5,376,859
ELIGIBLE MEMBER MONTHS	90	90	91	132	151	
COST PER ELIGIBLE	\$ 6,550	\$ 8,575	\$ 11,268	\$ 9,242	\$ 11,724	
TREND RATES						5-YEAR AVERAGE
ANNUAL CHANGE						
TOTAL EXPENDITURE		30.92%	32.86%	18.97%	45.13%	31.64%
ELIGIBLE MEMBER MONTHS		0.00%	1.11%	45.05%	14.39%	13.81%
COST PER ELIGIBLE		30.92%	31.40%	-17.98%	26.87%	15.67%

EXHIBIT 5-B

Annual and 5 –Year Expenditure Projections Under the Current System

MANDATORY POPULATIONS									
ELIGIBILITY GROUP	Historical	Estimated	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
				SFY 05	SFY 06	SFY 07	SFY 08	SFY 09	
Nursing Facility Residents									
Eligible Member Months	-2.03%	1.00%	36	2,246	2,269	2,291	2,314	2,337	
Total Cost Per Eligible	7.15%	7.15%	36	\$ 51,590	\$ 55,279	\$ 59,231	\$ 63,466	\$ 68,004	
Total Expenditure				\$ 115,873,804	\$ 125,400,369	\$ 135,710,161	\$ 146,867,571	\$ 158,942,289	\$ 682,794,194
HCBS									
Eligible Member Months	10.01%	8.00%	36	1,127	1,218	1,315	1,420	1,534	
Total Cost Per Eligible	18.56%	18.56%	36	\$ 35,970	\$ 42,647	\$ 50,562	\$ 59,946	\$ 71,072	
Total Expenditure				\$ 40,554,557	\$ 51,928,001	\$ 66,491,105	\$ 85,138,403	\$ 109,015,297	\$ 353,127,363
HCBS-ERC									
Eligible Member Months	13.81%	11.00%	36	207	229	254	282	314	
Total Cost Per Eligible	15.67%	15.67%	36	\$ 18,145	\$ 20,988	\$ 24,277	\$ 28,081	\$ 32,482	
Total Expenditure				\$ 3,747,148	\$ 4,811,102	\$ 6,177,152	\$ 7,931,073	\$ 10,182,999	\$ 32,849,473
Total Plan Expenditure				\$ 160,175,509	\$ 182,139,472	\$ 208,378,417	\$ 239,937,047	\$ 278,140,585	\$ 1,068,771,030

EXHIBIT 5-C DEMONSTRATION WITH WAIVER (W/W) BUDGET PROJECTION

STATE PLAN POPULATIONS

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	
Nursing Facility Residents								
		eligibles entering HCBS rather than NF						
NF to HCBS members			180	193	206	220	234	
Eligible Members	1.00%	36	2,066	2,076	2,085	2,094	2,104	
Total Cost per Eligible	7.15%	36	51,590	55,279	59,231	63,466	68,004	
Total Expenditure			\$ 106,603,900	\$ 114,741,338	\$ 123,496,246	\$ 132,915,152	\$ 143,048,060	\$ 620,804,696
HCBS								
		eligibles entering HCBS rather than NF						
NF to HCBS members								
Eligible Members	8.00%	36	1,127	1,218	1,315	1,420	1,534	
Total Cost per Eligible	18.56%	36	35,970	42,647	50,562	59,946	71,072	
Total Expenditure			40554556.79	51928001.13	66491105.19	85138402.66	109015297.4	353127363.2
HCBS-ERC								
		eligibles entering HCBS rather than NF						
NF to HCBS members								
Eligible Members	11.00%	36	207	229	254	282	314	
Total Cost per Eligible	15.67%	36	18,145	20,988	24,277	28,081	32,482	
Total Expenditure			\$ 3,747,148	\$ 4,811,102	\$ 6,177,152	\$ 7,931,073	\$ 10,182,999	\$ 32,849,473
Total Plan Expenditure			\$ 150,905,605	\$ 171,480,441	\$ 196,164,503	\$ 225,984,628	\$ 262,246,356	\$ 1,006,781,532
Total New Expenditure			\$ 9,960,000	\$ 10,557,600	\$ 11,191,056	\$ 11,862,519	\$ 12,574,271	\$ 56,145,446
Total WW Expenditure			\$ 160,865,605	\$ 182,038,041	\$ 207,355,559	\$ 237,847,148	\$ 274,820,626	\$ 1,062,926,978
Total WOW Expenditure			\$ 160,175,509	\$ 182,139,472	\$ 208,378,417	\$ 239,937,047	\$ 278,140,585	\$ 1,068,771,030
SAVINGS			\$ (690,096)	\$ 101,431	\$ 1,022,858	\$ 2,089,900	\$ 3,319,958	\$ 5,844,052

EXPANSION POPULATIONS

ELIGIBILITY GROUP	ANTICIPATED FIGURES	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
				DY 01	DY 02	DY 03	DY 04	DY 05	
High Needs									
			Enrollees	120	127	135	143	151	
Eligible Member Months	\$ 1,440	6.00%		1,440	1,526	1,618	1,715	1,818	
Total Cost per Eligible	\$ 5,500		0	\$ 5,500	\$ 5,500	\$ 5,500	\$ 5,500	\$ 5,500	
Total Expenditure	\$ 7,920,000			\$ 7,920,000	\$ 8,395,200	\$ 8,898,912	\$ 9,432,847	\$ 9,998,818	\$ 44,645,776
Moderate Needs									
			Enrollees	250	265	281	298	316	
Eligible Member Months	\$ 3,000	6.00%		3,000	3,180	3,371	3,573	3,787	
Total Cost per Eligible	\$ 680		0	\$ 680	\$ 680	\$ 680	\$ 680	\$ 680	
Total Expenditure	\$ 2,040,000			\$ 2,040,000	\$ 2,162,400	\$ 2,292,144	\$ 2,429,673	\$ 2,575,453	\$ 11,499,670
Total NEW Expenditure	\$ 9,960,000			\$ 9,960,000	\$ 10,557,600	\$ 11,191,056	\$ 11,862,519	\$ 12,574,271	\$ 56,145,446

EXHIBIT 5-D

SUMMARY SHEET

5 Year Historical Trends Summary for Mcaid			
	cost	elig	pmpm
Pop 1 in state history	4.98%	-2.03%	7.15%
Pop 1 in wow		1.00%	7.15%
Pop 2 in history	30.43%	10.01%	18.56%
Pop 2 in wow		8.00%	18.56%
Pop 3 in history	30.92%	32.86%	18.97%
Pop 3 in wow		11.00%	15.67%

WITHOUT WAIVER BUDGET TOTAL	\$ 1,068,771,030
WITH WAIVER SP TOTAL	\$ 1,006,781,532
5 year Demo Population Costs	\$ 56,145,446
SAVINGS	\$ 5,844,052

ELIGIBLES ENTERING HCBS RATHER THAN NF						
	1	2	3	4	5	total or ave
Pop 1 WOW	2246	2,269	2,291	2,314	2,337	11,457
Pop 1 W/W	2066	2,076	2,085	2,094	2,104	10,425
MMs new HCBS	2,156	2,314	2,474	2,638	2,805	1,032
Indivs new HCBS	180	193	206	220	234	86
% change	8%	8%	9%	9%	10%	9%
Pop 2 WOW	1127	1218	1315	1420	1534	6614
Pop 2 W/W	1127	1218	1315	1420	1534	6614
MMs new HCBS	-	-	-	-	-	-
Indivs new HCBS	0%	0%	0%	0%	0%	0%
% change	0%	0%	0%	0%	0%	0%
Pop 3 WOW	207	229	254	282	314	1286
Pop 3 W/W	207	229	254	282	314	1286
MMs new HCBS	-	-	-	-	-	-
Indivs new HCBS	0%	0%	0%	0%	0%	0%
% change	0%	0%	0%	0%	0%	0%

Chapter 6: Research and Evaluation Plan

Vermont will conduct an evaluation of the Demonstration in cooperation with the Independent Evaluator selected by CMS. Vermont takes seriously the evaluation component of the Demonstration and is anxious to develop meaningful data and analyses that can guide the program as it evolves. Accordingly, DA&D intends to utilize the Evaluation process as a part of its Continuous Quality Improvement activities, taking the opportunities inherent in the process to garner substantial information on the effects and impact of the Demonstration on the lives of its participants and the long-term care system in general.

As a part of the evaluation, the Department of Aging and Disabilities will seek answers to the following questions regarding the effect of the project on the long-term care system and its participants.

Evaluation Questions and Methodologies

Question #1: Which functional, cognitive, and medical measures are the best predictors of individuals at risk for institutional placement in the medium term (twenty four months or less)?

Methodology: The State will collect functional, cognitive and clinical measures from assessment tools used in the program and track the institutional status of each Demonstration enrollee to identify any correlation between these measures and the timing of any subsequent admission to a nursing facility.

Question #2: Is it more cost effective for the overall long-term care program to furnish a comprehensive package of HCB services to individuals, based on their specific needs, than to operate a system where there is an institutional bias (the current system)? Does the Demonstration achieve lower costs overall than the system's historical costs? What are the per

enrollee per year costs (PEPY) under the Demonstration versus the historical per recipient per year costs?

Methodology: Vermont has extensive data on the cost of the current long-term care program on an aggregate and per recipient basis. Going forward under the Demonstration, costs will be closely tracked and compared to these historical benchmarks.

Question #3: If enrollee needs are adequately assessed and a care plan comprised of HCB services is implemented early enough, can the need for nursing facility care be significantly delayed or eliminated? Are there population characteristics that are accurate predictors of the degree of delay or elimination?

Methodology: Information collected during the Referral Intake and Preliminary Assessment Process, and the Evaluation of Individual Enrollee Clinical Needs and Social Supports will be analyzed to determine the degree to which early intervention impacts the likelihood of a subsequent nursing facility admission. These data will also be analyzed to ascertain if certain population characteristics (e.g., spouse living in the home, residing with adult children, living alone, etc.) appear correlated with higher or lower rates of nursing facility admission and the timeframes in which the admission occurs.

Question #4: Do pre- and post-implementation survey results indicate that enrollees are more satisfied under the Demonstration than was historically the case with the fee-for-service long-term care program? Are the results different for enrollees who were previously served in the 1915(c) waiver programs?

Methodology: The state will conduct pre- and post-implementation surveys to establish both a baseline (pre-implementation survey) and to collect comparable data post-implementation, at intervals to be determined. Pre-implementation surveys will be conducted with two distinct groups of recipients – those enrolled in one of the 1915(c) waivers and those receiving long-term care services outside of any HCBS waiver.

Question #5: Does the Demonstration impact the array and amount of services available in the community? Does this vary by the geographical region of the state? What are the pre- and post-Demonstration service inventories in each region of the State?

Methodology: The State will assemble a pre-implementation inventory based on DA&D's current information with respect to resources in the community. At the end of Year 3 of the Demonstration, the State will assemble a new inventory and compare changes by geographic region and type of service.

Question #6: What impact does the Demonstration have on nursing facility census in the State? What impact does the Demonstration have on nursing facility acuity levels?

Methodology: Nursing facility occupancy rates and acuity levels will be continuously monitored throughout the Demonstration.

Question #7: Do the educational programs expand the level of knowledge in the community with respect to long-term care resources, including Medicaid (based on pre- and post-implementation surveys)?

Methodology: The State will conduct written, telephone or focus group surveys before, and at one-year intervals after, implementation of the Demonstration to assess the impact of its educational programs.

Question #8: Does presumptive eligibility for the long-term care population “work”, that is, are the vast majority of recipients ultimately found to meet the eligibility criteria when a comprehensive review is completed. What are the costs of the presumptively eligibility program?

Methodology: The State will track the reasons and costs for all enrollees found ineligible for the Demonstration, but who were receiving services temporarily as a presumptive eligible. The State will also track the total numbers of persons served as presumptive eligibles.

Conduct Surveys

The Evaluation Plan envisions a series of pre-implementation surveys to establish a baseline of recipient satisfaction with the current long-term care Medicaid program, including the existing HCBS waiver programs. A pre-implementation survey will also be conducted to determine the level of knowledge of Vermont residents with respect to the availability of long-term care services in the local communities and the rules and eligibility requirements for obtaining Medicaid coverage.

A region-by-region inventory of home- and community-based long-term care services and resources will also be taken. DA&D, in cooperation with OVHA, will establish baseline cost and utilization information for the existing Medicaid long-term care program consistent with the historical data provided in Chapter 5 – Caseload and Cost Estimates.

DA&D expects to conduct these surveys and inventories immediately upon approval of the waiver and before full implementation of the Demonstration program. DA&D will consult with the independent evaluator selected by CMS for this 1115 waiver on the design and execution of such surveys.

Chapter 7: Demonstration Administration

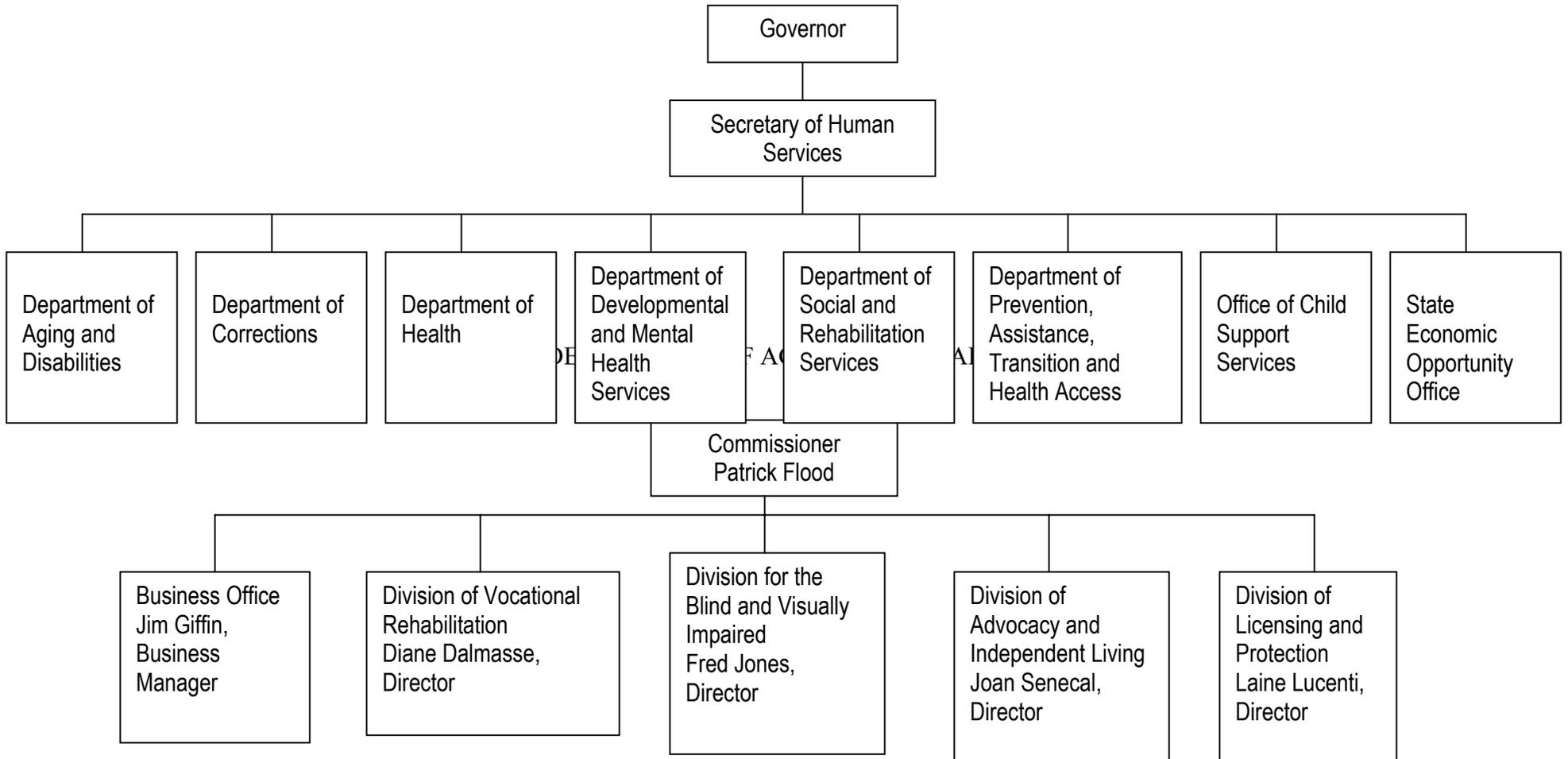
Overview of Organizational Change

The Demonstration will be administered by the Department of Aging and Disabilities (DA&D), within the Agency of Human Services for the State of Vermont. The Department's Commissioner, Patrick Flood, will serve as the Executive Officer for the Demonstration. Joan Senecal, Director, Division of Advocacy and Independent Living, will serve as the day-to-day Operational Director for the program.

DA&D will receive a global budget from the Agency of Human Services to conduct the Demonstration. That budget will be equal to the fee-for-service equivalent cost of the pre-waiver long-term care program. DA&D will re-organize its core business operations under the Demonstration to function as a managed long-term care plan. These functions are described in this Chapter. DA&D will meet the requirements of the 1997 Balanced Budget Act with respect to the operation of managed care programs

DA&D will maintain close-working relationships with other State agencies, departments and divisions affected by the Demonstration. This includes the various departments within the Agency of Human Services.

AGENCY OF HUMAN SERVICES ORGANIZATIONAL CHART

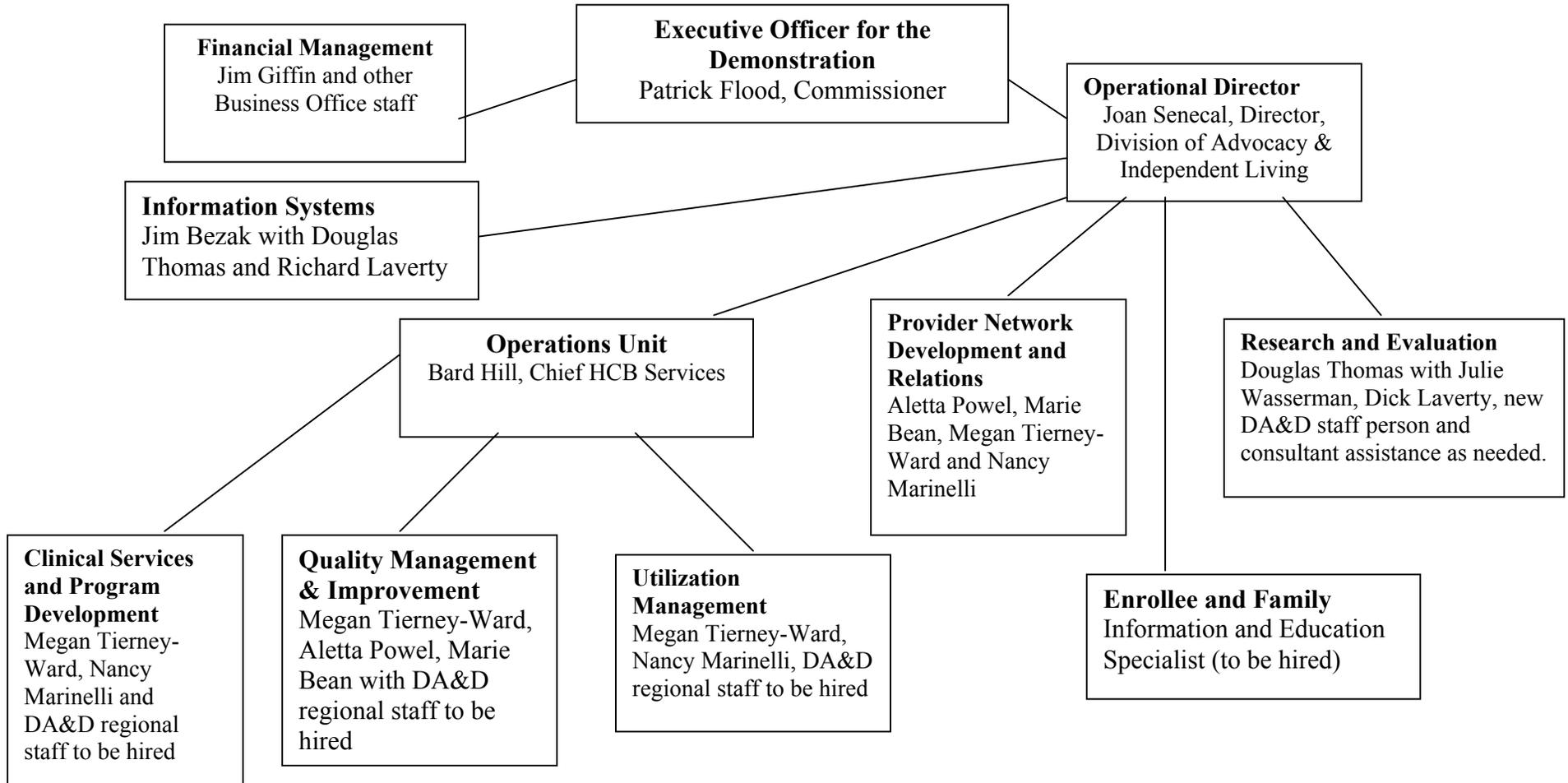


Proposed Demonstration Administration and Management

The Department has identified eight functional areas necessary to support its core business operations for the Demonstration. These units have responsibility for distinct operational processes necessary to administer the Demonstration.

- Clinical Services and Program Development
- Provider Network Development and Relations
- Quality Management and Improvement
- Research and Evaluation
- Enrollee and Family
- Utilization Management
- Financial Management
- Information Systems

**1115 LONG-TERM CARE WAIVER
FUNCTIONAL ORGANIZATION CHART**



- The DA&D Division of Licensing and Protection is the survey and certification agency for all nursing facilities, residential care/assisted living and home health agencies. DLP will work closely with the Quality Management and Improvement and Utilization Management Units.

The roles and responsibilities of each functional area are described in this Chapter. The functions in many respects mirror the operational units within most managed care organizations. This is appropriate given the functional role that DA&D is assuming under the Demonstration. The Department will operate as the managed long-term care plan for the State. Accordingly, it will have in place the necessary administrative and financial services to operate a long-term care managed care organization.

Description of the Operational Units

Clinical Services and Program Development

This Unit is responsible for the overall design of the Demonstration and the policies and procedures governing its implementation and operations. This includes policies related to benefit design, service coverage and delivery, the use of uniform assessment and evaluation tools, and care plan content. Clinical Services and Program Development staff are also responsible for designing and disseminating procedures with respect to emergency contingency plans for Demonstration enrollees.

Enrollee and Family Services

This Unit is responsible for Enrollee Outreach and Educational programs, Grievances and Appeals, and Enrollee Inquiry Response (done by the Medicaid Member Services Unit). The Unit maintains an Enrollee HelpLine where referrals for Intake and Preliminary Assessments can be made and individuals can obtain basic information about the Long-Term Care Demonstration program.

Provider Network Development and Relations

This Unit is responsible for network development and contracting with long-term care providers. Staff provide oversight of providers and identify and address shortfalls in the network. The Unit is also responsible for Provider Education and Provider Appeals. They respond to inquiries from physicians in the community with respect to eligibility for, and services provided under, the Demonstration.

Utilization Management

This Unit is responsible for all Utilization Review activities, including monitoring of care plan content and delivery of services. The UM staff will monitor the actual provision of care through claims analysis, and evaluate the medical necessity and appropriateness of care delivered to beneficiaries on a retrospective basis. UM staff will approve all nursing facility admissions and coordinate discharge planning activities with Certified Case Managers.

Quality Monitoring and Management

This Unit has ultimate responsibility for the quality of care and services provided under the Demonstration. The Unit conducts quality oversight of regional home health agencies and Area Agency on Aging Certified Case Managers. It also evaluates service providers to ensure that quality of care issues are identified and addressed. In conjunction with the UM staff, this Unit conducts audits and reviews of care plans and budgets.

Financial Management

This Unit has overall responsibility for ensuring that the Department functions within the global budget for the Demonstration. The Unit conducts financial analyses and provides financial projections of obligated but unincurred costs under approved comprehensive care plans. The

Unit provides periodic reports to the Executive Officer and Operational Director on the financial status of the Demonstration.

Research and Evaluation

This Unit is responsible for coordinating with the CMS-designated Independent Evaluator on the design and execution of the Evaluation Plan. The Unit conducts surveys and statistical analyses of data and information on the impact of the program in key evaluation areas. The staff test hypotheses with respect to outcomes under the Demonstration and reports program results to the Executive Officer and Operational Director.

Information Systems

This Unit is responsible for the systematic collection, processing and storage of all data and information on the Demonstration. It is also responsible for developing databases and automated solutions for capturing and analyzing the content of the comprehensive care plans and their associated budgets.

Chapter 8: Public Notice and Community Support

Public Notice and Feedback

Vermont routinely seeks public input when major changes are proposed for any part of the long-term care system. Because this application proposes a significant change from the long-held public policy that creates a bias toward institutional care, DA&D has taken a number of steps to ensure that interested parties are, and will continue to be, fully informed about the proposal and have ample opportunity to comment. In addition, DA&D will continue meeting with the various workgroups that are assisting with the many details that must be clarified prior to implementation.

First Stage of Public Notice and Input

Nine public meetings were held during June 2003. The meetings were convened by the ten community-based Long-Term Care Coalitions, which encompass the entire state. Over 400 people attended these meetings. The Coalitions used funds from Vermont's Real Choice System Change Grant to publicize and organize the meetings. The Commissioner of the Department of Aging and Disabilities and/or the Director of the Division of Advocacy and Independent Living gave an MS PowerPoint presentation on the purpose, program goals, concepts and next steps for the waiver application. Comments and suggestions were received at each meeting and then presented, by Coalition area, on the DA&D website.

At the end of each meeting, participants were invited to sign up for various work groups that would assist DA&D in developing policies and procedures to handle the myriad of implementation details. Approximately 150 individuals signed up for the work groups. These groups are: Eligibility; Navigating the System (developing operational protocols between DA&D staff and local agencies); Public Information and Education; Cash and Counseling Pilot; and Quality Assurance/Quality Improvement. Meetings of the Eligibility and Navigating the System groups were immediately held using Vermont Interactive Television (ITV). All ITV sites were

made available to encourage maximum participation. Work group meetings will continue through the fall and early winter.

The DA&D Commissioner also provided separate briefings to the Governor and his staff, the Legislative Health Access Oversight Committee and for the Chairs of the Senate and House Health and Welfare Committees. He also held several separate meetings with the executive directors of the home health agencies, Area Agencies on Aging and a meeting with the directors of the Adult Day Centers.

The Division Director held briefing with the Governor's Commission on Alzheimer's Disease and Related Disorders, the Medicaid Advisory Board and the Eligibility Committee for the Attendant Services Program.

Second Stage of Public Notice and Input

Over the summer, a draft proposal was developed, which incorporated many of the ideas gleaned from these meetings. The draft was circulated for comment in early September. Over 300 individuals received copies of the draft and were invited to submit their input. An ITV meeting, again using all the sites, was held to elicit more discussion about the proposal and to receive verbal comments. The organizations that received copies and provided written feedback, include: the Vermont Health Care Association (represents nursing facilities and many residential care homes); the Area Agencies on Aging; the Community of Vermont Elders; the State Health Care Ombudsman; the Disability Law Project, the State Long-Term Care Ombudsman; the Vermont Assembly of Home Health Agencies; the Vermont Association of Hospitals and Health Systems; the Vermont Coalition for Disability Rights; AARP; and DA&D's sister agency, the Department of Prevention, Assistance, Transition and Health Access (PATH).

During every step of the development process, the Commissioner held discussions with the Department of Aging and Disabilities' Advisory Board at its monthly meetings. The DA&D Advisory Board will continue to function as the oversight board for this long-term care program. Meetings are always open to the public and many advocacy groups are represented either on the board or as regular guests at the board meetings.

Chapter 9: Waivers Requested

In order to operate the Demonstration described in this proposal, the State of Vermont will require the following waivers for statutory and regulatory requirements of the Title XIX Medical Assistance Program.

1902(a)(1) - The State requests a waiver of the Statewideness requirements set forth in the Section to permit it to offer different types of Home- and Community-Based Services in different geographic regions of the State.

1902(a)(10) – The State requests a waiver to enable it to provide non-Medicaid State Plan services to the Demonstration population.

1902(a)(10)(b) - The State requests a waiver of the Comparability requirements set forth in the Section to permit it to provide services to individuals served under the waiver that are not available to Medical Assistance recipients who are not enrolled in the waiver and to impose different levels of resources for persons electing home-based care.

1902(a)(10)(b) - The State requests this waiver to permit it to restrict the amount, duration and scope of services provided to a Demonstration enrollee to those services included on the approved Comprehensive Care Plan.

1902(a)(10)(C)(i)(III) - The State requests a waiver of this section to use institutional income and resource rules for the medically needy, with resource limits set at \$10,000 for enrollees electing home-based services in lieu of nursing facility or other residential care services in licensed settings.

1902(a)(17) - The State requests a waiver of this section to enable it to consider only the individual's income and resources when applying for the waiver as a Moderate Needs group

member and to offer 1 month spenddowns for people receiving community-based services as an alternative to institutionalization. Additionally this waiver will permit the State to disregard quarterly income totaling less than \$20 from the post-eligibility income determination.

1902(a)(23) - The State requests a waiver of this section to enable it to restrict freedom of choice of provider.

1902(a)(14) - The State requests this waiver to enable it to impose cost sharing on certain services.

1902(a)(34) - The State requests this waiver to permit it to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made under this Demonstration for Expansion eligibles.

1902(a)(32) - The State requests a waiver of this requirement to permit it to provide reimbursement, through tax credits granted by the Vermont Department of Taxes, to persons purchasing qualified individual long-term care insurance policies.

1902(a)(10)(A) and 1902(a)(10)(C)(I)(III) - The State is requesting these waivers to permit it to use streamlined eligibility procedures, along with streamlining the Medically Needy process, and include eligibility standards and requirements that differ from those required by law.

1902(a)(18) and 1902(a)(17)(b) - The State requests this waiver to enable it to develop standards (subject to CMS approval) that permit Vermont to count income that has been transferred, within 12 months prior to application for assistance or at anytime while receiving medical assistance, for less than fair market value, unless transferred solely for purposes other than to obtain or maintain medical assistance under the Demonstration.

1902(a)(4)(A) (as implemented by 42 CFR 431.804, 431.806(a), 431.810-431.816, 431.820-431.822 and 431.865 except that the regulatory definitions of “claims processing error” and

“state agency” shall continue to be applicable) – The State is requesting this waiver to enable it to employ a Medicaid Eligibility and Quality Control System that varies from that required by the cited statute.

The State also requests any additional waivers that CMS deems are needed to operate the demonstration, including any additional waivers necessary to include the non-State Plan services in the long-term care benefit package described in this proposal.

Also Vermont requests that the Secretary, under the authority of Section 1115(a)(2) of the Act, consider expenditures made by the State of Vermont for the items identified below (which are not otherwise included as expenditures under Section 1903) shall, for the purposes of this Demonstration and the period of this project, be regarded as expenditures under the State’s Title XIX Plan:

- Expenditures to provide home- and community-based services to individuals who would not otherwise be eligible for Medicaid, because they are not at immediate risk of institutionalization absent the provision of the HCB services.
- The amount of individual tax credits provided to individuals purchasing approved long-term care insurance policies.
- Expenditures that would have been disallowed under Section 1903(u) of the Act based upon Medicaid Eligibility Quality Control findings.
- Expenditures for services provided by caregiver spouses approved by the State to provide care on a compensated basis.
- Expenditures for services provided during a period of presumptive eligibility.

Chapter 10: Implementation Plan

The Vermont Department of Aging and Disabilities will implement the proposed long-term care reform program in phases beginning July 1, 2004. Prior to that date, the State will put in place the infrastructure and systems required to administer the Demonstration. This chapter provides a brief overview of the State's timeframes and plan for implementing the Long-term Care Demonstration.

Pre-Implementation Activities

DA&D will undertake a number of activities in preparation for the implementation of the Demonstration. Those activities and their respective timeframes are presented in an overview of the State's Pre-implementation Work Plan at the end of this Chapter.

Phased Implementation

In the first phase, which will begin July 1, 2004, the State will enroll all existing long-term care recipients in the Demonstration program. The resource limit will be raised to \$10,000 from \$2,000 for persons found eligible and participating in home-based services after that date, with cost sharing for home and community based services for individuals with resources above \$2,000. Cost sharing will be established on an annual basis and will range from \$50-100 per month, depending on the enrollee's actual level of resources as determined at the time of eligibility determination or re-certification. Cost sharing shall be accomplished through the payment of co-payments.

Presumptive eligibility will be implemented in the first phase for individuals in the Highest Need group. Based on the outcome of that process over the first six months of the Demonstration, the presumptive eligibility process will be expanded to include those enrollees in the High Needs group.

The provision of services to persons in the Highest Need group will be the first priority of the program. Those enrollees will be eligible for all Core services based on medical necessity and individual circumstances, as specified in their individual plan of care. Enrollees in the High Needs group will have second priority status and will be eligible for Core services to the extent that funds are available beginning November 2004. The Moderate Needs group will have third priority status. At a minimum; however, enrollees in the High and Moderate Need groups will receive case management services. These enrollees will also have access to some level of homemaker and adult day services if their conditions and circumstances indicate that these services are essential to assisting them to maintain their independence in the community. (Full implementation of services for the Moderate Needs group will be in July 2005, assuming funds are available.)

During Phase I, DA&D will also “kick off” the Statewide Educational Initiative. This initiative will include a comprehensive campaign using multi-media approaches to providing information to the public about the long-term care programs and resources available in the State.

During Phase I, the Long-Term Care Ombudsman program will also be expanded from the current model, which serves residents in nursing facilities and residential care homes, to a more comprehensive initiative encompassing the full range of long-term care services.

During Phase II of the Demonstration, beginning July 1, 2005, enrollment will be expanded to include optional services for the Highest Need group and additional Core services for as many High and Moderate Needs group enrollees as can be sustained with the available funding. The precise level of service provision for the High and Moderate Needs groups will be based on available resources, with the members of the High Needs group being served first. A prioritization methodology will be used to determine which individuals will receive what level of services.

Finally, Phase II will also see the inclusion of the private long term care insurance initiative to encourage Vermonters to purchase long-term care insurance policies. It is anticipated that some

type of state tax incentive will be offered, as determined by the Administration and Legislature. During this phase the State will also expand the number of High and Moderate Need persons being served and add Optional services to the benefit package for these two groups, if funds are available under the waiver.

The table below shows the phase-in of the various components of the new long-term care program.

IMPLEMENTATION OF VERMONT'S LONG-TERM CARE 1115 WAIVER

	July –Oct. 04	Nov. – Feb. 05	Mar. - June 05	July – Oct. 05	Nov. – Feb. 06	Mar. - June 06	July – Oct. 06	Nov. – Feb. 07	Mar. - June 07
Phase I									
Enroll current long-term care recipients	X								▶
Start presumptive eligibility for Highest Need Group	X								▶
Provide services to Highest Need Group	X								▶
Provide services (in addition to case management) to High Need Group, depending on available funds		X							▶
Provide case management services to Moderate Need Group	X								▶
Public Information/Educational Campaign		X							▶
Expand LTC Ombudsman Program to Home-Based Care			X						▶
Phase II									
Based on success in Phase I, implement presumptive eligibility for High Need Group				X					▶
Provide services to Moderate Need Group (in addition to case management and some adult day and homemaker services)				X					▶
Expansion of optional services for Highest Need group and Core services for as many High and Moderate Needs group enrollees as can be sustained with available funding				X					▶
Expand the number of High and Moderate Need enrollees and add Optional Services for these groups; earlier if funds allow				X					▶
Encourage Vermonters to purchase LTC Insurance policies				X					▶

**Long-Term Care Demonstration Waiver
Summary of Pre-Implementation Work Plan**

AREA	TASK	Estimated Completion Date
DA&D staffing/mgmt		
	Refine new organizational structure for 1115 Waiver management	12/1/03
	Develop job descriptions and file PER-10s for new positions and existing DAIL staff; request positions from Dept. of Personnel Position Pool	1/1/04
	Hire, orient, train new staff	4/1/04
	Set up space: home office or in regional offices. Purchase equipment: laptops, modems, printers, file cabs, phones, desks, etc.	6/1/04
	Ensure that computers have CITRIX capacity for secure connections	6/1/04
	Develop details of supervision/communication between Central Office and field staff	6/15/04
	Develop Memorandum of Agreement between the Department of Aging and Disabilities (DA&D) and the Department of Prevention, Assistance, Transition and Health Access (PATH) – (houses the State Medicaid Division)	4/1/04
	Update UR procedures and coordinate with the DA&D Division of Licensing and Protection (DLP)	4/1/04
	Develop short form assessment for initial Plan of Care (POC)	4/1/04
	Clinical eligibility- automate as much as possible, test and refine	6/1/04
	Financial eligibility- automate as much as possible, test and refine	6/1/04
	Develop waiting list/reporting procedures	6/1/04
	Develop encrypted email capacity between DA&D and regional staff	5/1/04
	Incorporate data from DAILCARE database (Waiver cases) into SAMS2000 database (comprehensive database for DA&D clients)	TBD
	Revise POC forms, print, distribute. Deliver training on new forms.	6/1/04

AREA	TASK	Estimated Completion Date
Interactions with Local Organizations		
	Finalize local/DA&D protocols for referrals, enrollment procedures, UR, Waiver Team meetings, sharing of client information via meetings with workgroup.	6/1/04
Regulations and Ongoing Oversight	Create workgroup and issue invitations and meeting schedule	10/1/03
	Define purpose and scope of regulations	11/18/03
	Draft regulations	2/1/04
	Distribute for public comment	2/15/04
	Revise regulations	3/15/04
	Promulgate through APA process	5/1/04
	Continue to use the DA&D Advisory Board meetings as the place where discussion and oversight occur	On-going
	Appeals: Clarify procedures for 4 types of appeals: clinical (program eligibility and group eligibility); financial eligibility; services included in the Plan of Care; and prioritization of waiting lists for High Need and Moderate Need groups	6/1/04
LTC financial eligibility		
	PATH and DA&D develop procedures for each eligibility group	3/15/04
	PATH ACCESS creates system codes for each eligibility group	4/1/04
	DA&D regional staff, case mgs/providers and trained on new procdures	6/1/04
	Presumptive eligibility procedures are developed	4/1/04
	DA&D staff, PATH staff and local case managers are trained on new procedures	6/1/04
	Strengthen current Estate Recovery Law to the extent possible	On-going

AREA	TASK	Estimated Completion Date
LTC clinical eligibility		
	Procedures developed for each group	3/15/04
	Application developed with integrated eligibility screens	4/1/04
	DA&D staff and local case managers and providers are trained on new standards	6/1/04
	Prioritization policies and procedures are developed to be used with Long Term Care team for High Needs group.	6/1/04
Financial systems: Payments, tracking, management		
	Administrative budget/plan developed	3/1/04
	Statewide and regional budget plans developed	4/1/04
	Methodology developed for determining whether all enrollees in the entitlement (Highest Need) group are being served. Develop process for determining if funds are available to serve persons in the High Need group and Moderate Need group. Establish methodology for allocating those funds by local area.	5/1/04
	New services/rates on file at EDS (Medicaid claims processing system)	6/1/04
	New Cash/& Counseling financial payment via Intermediary Service Organization is set up	6/1/04
	PATH ACCESS system (Medicaid eligibility tracking system) links to EDS for claims processing	6/1/04
	Develop new eligibility/payment mechanisms for Adult Day grants	3/1/04
	Grant agreements signed with Adult Day Centers	7/1/04
	Develop new eligibility/payment mechanisms for Homemaker grants	3/1/04
	Grant agreements signed with Adult Day Centers	7/1/04
	Move Social Service Block Grant (SSBG) funding into the Attendant Services Program (ASP); develop Medicaid eligibility tracking procedures for ASP	7/1/04

AREA	TASK	Estimated Completion Date
Training local staff (case managers and providers)		
	Meet with each LTC team re: new processes	5/1/04
	Revise team protocols; include Nursing Facility and Residential Care Home staff in the process	6/15/04
	Conduct bimonthly statewide LTC meetings	On-going
	Develop new policy/procedures manual and post on DA&D website	6/15/03 – changes on-going
Research/evaluation		
	Meet with CMS research and evaluation team to refine research questions and data collection methodologies	TBD
	Set up internal research team and data collection methodologies for research that DA&D is specifically interested in that might not be covered by the CMS researchers	5/1/04
	Analyze data and create reports	
	Proceed as instructed by CMS	TBD
Operational Protocols	Draft protocol and submit to CMS for comments	1/31/04
	Receive input from CMS and finalize document	3/1/04
	Post final Operational Protocol on DA&D website	3/15/04
QA/QI	Develop protocols and procedures based on work from the QA/QI workgroup and CMS guidance when available. Integrate procedures with exiting procedures in the Division of Licensing and Protection.	2/15/04
	Assign QA/QI tasks to DA&D staff	5/1/04
	Create standard review forms/documents	5/15/04
	Distribute protocols to local providers and post on DA&D website	6/1/04
	Implement new QA/QI protocols and procedures	7/1/04
	Continue DA&D consumer surveys	On-going
	Expand Ombudsman program to home-based settings	3/1/05

AREA	TASK	Estimated Completion Date
Public Information and Education		
	Meet with workgroup to define scope and approach	11/1/03
	Review existing materials for information and education.	12/1/03
	Develop plan for multi-phase/multi-media program	1/15/04
	Develop RFP and contract with social marketing firm, if determined necessary	3/1/04
	Implement Plan	4/1/04
Cash & Counseling Pilot	Workgroup and DA&D refine methodology for pilot – guidelines for use of funds; QA/QI specific to the pilot; evaluation criteria; consumer selection criteria; case management function; interaction with Intermediary Services Organization	2/15/03
	Select pilot area(s): develop criteria for selection; issue Request for Interest; select pilot site(s)	4/1/04
	Provide training to case managers	5/1/04
	Consumers selected and trained	6/1/04
	Pilot starts	7/1/04
	Evaluation and decision to expand initiative with any necessary course corrections	7/1/05

APPENDIX A

APPENDIX A
VERMONT INDEPENDENT LIVING ASSESSMENT
COVER SHEET

Directions: Complete pages 1-9 for all AAA services, Homemaker program, Medicaid Waiver, Adult Day, ASP, and HASS program. **Arrow → indicates that the question is to be answered by the individual only.** For all other questions, if the individual is unable to answer questions, obtain information from family/caregiver(s) or legal representative(s) as necessary with appropriate authorization to release information. Highlighted "Assessor Action" notes appear when action may be necessary.

A. INDIVIDUAL IDENTIFICATION

1. Date of Assessment: _____ 2. Unique ID# _____
3. Name: _____
a. (Last) _____ b. (First) _____ c. (M.I.) _____
4. Also known as: _____
a. (Last) _____ b. (First) _____ c. (M.I.) _____
5. Phone _____ 6. SS# _____
7. DOB ____ - ____ - ____ 8. Age ____ 9. Gender a. M b. F
Month Day Year
10. Mailing Address: 11. Residence (if different than mailing):
a. Street/P.O. Box _____ a. Street _____
b. Town _____ b. Town _____
c. State _____ d. Zip _____ c. State _____

B. EMERGENCY CONTACT INFORMATION

1. Spouse/Partner: _____
a. (Name) _____ b. (Phone) _____
2. Primary Physician: _____
a. (Name) _____ b. (Phone) _____
3. Friend or relative (other than spouse/partner) to contact in case of an emergency:

a. (Name) _____ b. (Relationship) _____ c. (Work Phone) _____ d. (Home Phone) _____

C. DIRECTIONS TO HOME

SECTION 1: Intake

A. ASSESSMENT INFORMATION

1. Date: _____ 2. Initial Assess Reassessment Update

3. Individual's reason for requesting help: _____

4. Where interviewed:
 a. Home b. Hospital c. Nursing Home d. Adult Day e. Other _____

5. Did someone help the individual or answer questions for the individual? a. Yes b. No

6. a. If "Yes", helper's name: _____ b. Helper's relationship: _____

7. Primary language: _____

8. Communication/Language assistance needed for assessment? a. Yes b. No

9. If "Yes", type of assistance: _____

10. ILA completed by: _____ 11. Agency: _____

12. ILA being completed for which DA&D program (if applicable):
 a. Adult Day b. ASP c. HASS e. Homemaker e. Medicaid Waiver f. NONE

B. LEGAL REPRESENTATIVE

Check all that apply:

b. Name	c. Phone (W)	d. Phone (H)
1. a. <input type="checkbox"/> Power of Attorney		
2. a. <input type="checkbox"/> Representative Payee		
3. a. <input type="checkbox"/> Legal Guardian		
4. a. <input type="checkbox"/> *DPOA for Health Care		
5. a. <input type="checkbox"/> *Living Will/ Copy held by:		

6. *If no DPOA or Living Will, was information provided about advance directives? a. Yes b. No

C. DEMOGRAPHICS

1. What is your marital status?
 a. single c. civil union e. separated
 b. married d. widowed f. divorced g. information unavailable

2. What is your race or ethnic background?
 a. White e. Hispanic
 b. African-American f. info. unavailable
 c. Asian or Pacific Island g. Other: _____
 d. American Indian/Alaskan Native

3. Do you live in:
 a. house/mobile home e. residential care home
 b. private apartment f. nursing home
 c. apartment in senior housing g. information unavailable
 d. assisted living residence h. other (describe) _____

4. Do you live:
- a. alone
 - b. with spouse/partner
 - c. with spouse and child
 - d. with child or children (including adult child)
 - e. with others _____
5. Are you currently employed? a. Yes b. No
6. How many related people reside together in your household (counting yourself)?
- a. 1 person
 - b. 2 people
 - c. 3 people
 - d. 4 or more
 - e. info. unavailable
7. What is the estimated total monthly income for your household? (*Based on 2003 Federal Poverty Limits*)
- a. \$748 or less
 - b. \$1010 or less
 - c. \$1272 or less
 - d. \$1533 or less
 - f. \$1534 or more
 - g. info. unavailable

D. HEALTH RELATED QUESTIONS

D1. General Questions

1. ►How do you rate your health? Would you say that it is excellent, good, fair, or poor?
- a. **Excellent**
 - b. **Good**
 - c. **Fair**
 - d. **Poor**
 - e. **No response**
2. Were you admitted to a hospital for any reason in the last 30 days? a. Yes b. No
3. In the past year, how many times have you stayed overnight in a hospital?
- a. not at all
 - b. one time
 - c. 2 or 3 times
 - d. more than 3 times
4. Have you ever stayed in a nursing home, residential care home or other institution (including Brandon Training School and Vermont State Hospital)?
- a. Yes
 - b. No
5. Have you fallen in the last 3 months? a. Yes b. No
6. Do you use a walker or four-prong cane (or equivalent), at least some of the time, to get around?
- a. Yes
 - b. No
7. Do you use a wheelchair, at least some of the time, to get around? a. Yes b. No
8. In the past month how many days a week have you usually gone out of the house/building where you live?
- a. Two or more days a week
 - b. One day a week or less
9. How many days a week are you physically active for at least 30 minutes? This includes any activity that causes small increases in breathing or heart rate that you do for at least 10 minutes at a time. (Such as walking, gardening, housework, dancing.) _____ days/week

10. Do you **currently** have any of the following medical conditions or problems?

Skip #10 if completing Section 5: Health Assessment

	Yes	No		Yes	No
a. heart condition			l. ankle/leg swelling		
b. arthritis			m. urinary problems		
c. diabetes			n. speech problems		
d. cancer			o. hearing problems		
e. stroke			p. vision problems		
f. neurological condition			q. dementia		
g. breathing condition			r. depression		
h. digestive problems			s. mental health condition		
i. muscle or bone problems			t. anxiety		
j. chronic pain			u. OTHER:		
k. chronic weakness/fatigue					

11. How many prescription medications do you take?

D2. Functional Needs SKIP ADL/IADL checklist if completing Section 6: Functional Assessment

<i>ADL/IADL checklist</i>	<i>a. Without help?</i>		<i>b. If "No", do you have help?</i>		<i>c. If "Yes", do you have enough help?</i>	
	Yes	No	Yes	No	Yes	No
CAN YOU:						
1. get around inside your home?						
2. bathe?						
3. dress?						
4. get in and out of bed/chair?						
5. use the toilet?						
6. eat?						
7. manage personal hygiene?						
8. manage your money?						
9. do your laundry?						
10. do your shopping?						
11. take medication(s)?						
12. prepare your own meals?						
13. manage household maintenance?						
14. do ordinary housework?						
15. take out the garbage?						
16. use transportation?						
17. use the telephone?						

ADL/IADL Comments:

18. Do you need any of the following new, repaired or additional devices or home modifications to help you to continue to stay in your home? (Check all that apply)

- | | |
|--|--|
| a. <input type="checkbox"/> Eyeglasses | h. <input type="checkbox"/> Ramp |
| b. <input type="checkbox"/> Cane or walker | i. <input type="checkbox"/> Doorways widened |
| c. <input type="checkbox"/> Wheelchair | j. <input type="checkbox"/> Kitchen/bathroom modifications |
| d. <input type="checkbox"/> Assistive feeding devices | k. <input type="checkbox"/> Other: _____ |
| e. <input type="checkbox"/> Assistive dressing devices | l. <input type="checkbox"/> NONE OF THE ABOVE |
| f. <input type="checkbox"/> Hearing aid | |
| g. <input type="checkbox"/> Dentures | |

D3. Emotional Health

Script for #1-5 (optional) "Your emotional health is just as important as your physical health. We've just reviewed your current physical health conditions and now I'd like to review your current emotional health.

1. →Do you feel you have enough contact with family? a. Yes b. No c. No response
 2. →Do you feel you have enough contact with friends? a. Yes b. No c. No response

During this past month:

3. →*Have you often felt downhearted or blue? a. Yes b. No c. No response
 4. →*Have you been anxious a lot or bothered by your nerves? a. Yes b. No c. No response
 5. →*Have you felt hopeless or helpless at all? a. Yes b. No c. No response

*If "Yes" to questions #3, 4 or 5, complete Section 4: Emotional/Behavioral/Cognitive Status, A. Emotional Well-Being, page 12.

D4. Cognitive Orientation

Script for #1-4 (optional) "Now I'd like to ask a few questions to see how well you're keeping track of time (or of things). For example: "

1. →Could you please tell me what year it is? a. correct b. incorrect c. No response
 2. →Could you please tell me what month it is? a. correct b. incorrect c. No response
 3. →Could you please tell me what day of the week it is? a. correct b. incorrect c. No response
 4. →When you make a decision about something, in general how do you do it?
 a. Usually by myself
 b. Usually I talk it over with family or friends, but I make my own decision.
 c. Usually I talk it over with my family or friends, etc., and I do what they think best.
 d. I let other people (including spouse/partner and other family members, friends) make decisions for me.
 e. No response

◇Assessor Action ◇

- **HEALTH:** If significant medical issues are apparent, discuss and make appropriate referral/s to physician, home health agency, or other health professional(s).
- **FUNCTIONAL NEEDS:** If help needed with ADLs, IADLs, assistive devices or home modifications, discuss and make appropriate referrals for assistance.
- **EMOTIONAL HEALTH:** For emotional health issues, consider options for Area Agency on Aging Eldercare Clinician, Home Health social services, community mental health, or other counseling/mental health professional.

- **COGNITION:** If “incorrect” answer to cognitive orientation questions, consider referral/s to physician, mental health professional memory clinic etc

E. *The NSI DETERMINE Your Nutritional Health Checklist

Directions: Read the statements below. Circle “Yes” or “No”. Add up the “Yes” answers and check the nutrition score.

Nutrition Checklist	a. Yes	b. No
1. Have you made changes in lifelong eating habits because of health problems? (such as diabetes, high blood pressure, etc.)	2	0
2. Do you eat fewer than 2 complete meals a day?	3	0
3. Do you eat fewer than 5 servings (1/2 cup each) of fruit or vegetables every day?	1	0
4. Do you have fewer than 2 servings of dairy products (such as milk, yogurt, cheese) or tofu every day?	1	0
5. Do you have any of the following problems that make it difficult for you to eat? Biting ___ Chewing ___ Swallowing ___	2	0
6. Are there times when you do not have enough money to buy the food you need?	4	0
7. Do you eat most meals alone?	1	0
8. Do you take 3 or more prescribed or over-the-counter medications each day? (including aspirin, laxatives, antacids, herbs, inhalers, etc.)	1	0
9. Have you lost or gained 10 pounds or more in the last 6 months without trying? Loss ___ Gain ___	2	0
10. Are there times when you are not physically able to do one or more of the following? Shop for food Cook Eat on your own	2	0
11. Do you have 3 or more drinks of beer, wine or liquor almost every day?	2	0

12. Total “Yes” Score.....

--

What does your total “Yes” score mean? If it is:

- 0– 2 Good!** Recheck your nutritional score in 6 months.
- 3– 5 You are at moderate nutritional risk.** See what you can do to improve your eating habits and lifestyle. Your office on aging, senior nutrition program, senior citizens center, health department and/or physician can help. Recheck your nutritional score in 3 months.
- 6+ You are at high nutritional risk.** You may want to talk with your doctor, dietitian or other qualified health or social services professional. Talk with them about any problems you may have. Ask for help to improve your nutritional health.

***Adapted from the DETERMINE Your Nutritional Health Checklist developed by the Nutrition Screening Initiative**

Additional Nutrition Questions:

- 13. About how tall are you without your shoes? a. _____ inches b. info. unavailable
- 14. About how much do you weigh without your shoes? a. _____ pounds b. info. unavailable
- 15. Do you drink at least six (6) glasses of water, milk, fruit juice or decaffeinated beverage (excluding alcohol) each day? (one glass=8oz) a. Yes b. No c. info. unavailable
- 16. Do you eat at least two (2) servings of protein rich foods each day? (meat, fish, poultry, nuts, or legumes) a. Yes b. No c. info. unavailable

◆ Assessor Action ◆

If the individual is at "high nutritional risk" per the NSI checklist, or has other nutritional issues, discuss and recommend appropriate referrals to a registered dietician (AAA or Home Health), physician, or other qualified professional(s).

F. FINANCIAL RESOURCES

Directions: Complete only information necessary for program participation.

F1. Monthly Income:

Source	1. Individual	2. Spouse
a. Social Security		
b. SSI		
c. Retirement/Pension		
d. Interest		
e. VA Benefits		
f. Wages/Salaries/Earnings		
g. Other		
Total Income:		

F 2. Monthly Expenses:

a. Rent / Mortgage	\$
b. Property Tax	\$
c. Heat	\$
d. Utilities	\$
e. House Insurance	\$
f. Telephone	\$
g. Medical Expenses	\$
h. Other:	\$
i. Other:	\$
Total Expenses:	

F3. Savings/Assets:

TYPE	1. Bank/Institution	2. Account No.	3. Amount
a. Checking			
b. Savings			
c. CD			
d. Burial Account			
e. Life Insurance			(cash value)
f. Other			
g. Other			

4. Health Insurance: (check all that apply)

Yes	No			
		a. Medicare A	Effective date:	Medicare #
		b. Medicare B	Effective date:	Mo. Premium:
		c. Medigap	Company:	Mo. Premium:
		d. LTC Insurance	Company:	Mo. Premium
		e. Other		

Comments:

G. SERVICE/PROGRAM CHECKLIST *Indicate all current services/program involvement.*

Check all that apply. If none, check "NONE OF THE ABOVE". Refer to ILA Manual pages 25-30 for a description of services.

1a. Home Health Services	1b. Want to Apply (✓)
<input type="checkbox"/> Home Health Aide (LNA)	<input type="checkbox"/>
<input type="checkbox"/> Homemaker	<input type="checkbox"/>
<input type="checkbox"/> Hospice Services	<input type="checkbox"/>
<input type="checkbox"/> Nursing Services (RN)	<input type="checkbox"/>
<input type="checkbox"/> Social Work Services	<input type="checkbox"/>
<input type="checkbox"/> Therapy (PT/OT/ST)	<input type="checkbox"/>
<input type="checkbox"/> NONE OF THE ABOVE	
2a. Community-Based Care Programs	2b. Want to Apply (✓)
<input type="checkbox"/> Adult Day Services/Day Health Rehab	<input type="checkbox"/>
<input type="checkbox"/> Attendant Services Program	<input type="checkbox"/>
<input type="checkbox"/> Developmental Disability Services	<input type="checkbox"/>
<input type="checkbox"/> Medicaid Waiver (HB/ERC)	<input type="checkbox"/>
<input type="checkbox"/> Medicaid High-Tech Services	<input type="checkbox"/>
<input type="checkbox"/> Traumatic Brain Injury Waiver	<input type="checkbox"/>
<input type="checkbox"/> NONE OF THE ABOVE	
3a. Nutrition Services	3b. Want to Apply (✓)
<input type="checkbox"/> Commodity Supplemental Food Program	
<input type="checkbox"/> Congregate Meals (Sr. Center)	<input type="checkbox"/>
<input type="checkbox"/> Emergency Food Shelf/Pantry	<input type="checkbox"/>
<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/>
<input type="checkbox"/> Senior Farmer's Market Nutrition Program	
<input type="checkbox"/> NONE OF THE ABOVE	
4a. Social Services Programs	4b. Want to Apply (✓)
<input type="checkbox"/> Area Agency on Aging Case Management	<input type="checkbox"/>
<input type="checkbox"/> Community Action Program (CAP)	<input type="checkbox"/>
<input type="checkbox"/> Community Mental Health Services	<input type="checkbox"/>
<input type="checkbox"/> Dementia Respite Grant Program/NFCSP Grant	<input type="checkbox"/>
<input type="checkbox"/> Eldercare Clinician	<input type="checkbox"/>
<input type="checkbox"/> Job Counseling/Vocational Rehabilitation	<input type="checkbox"/>
<input type="checkbox"/> Office of Public Guardian	<input type="checkbox"/>
<input type="checkbox"/> Senior Companion Program	<input type="checkbox"/>
<input type="checkbox"/> VCIL Peer Counseling	<input type="checkbox"/>
<input type="checkbox"/> VT Assoc. for the Blind and Visually Impaired	<input type="checkbox"/>
<input type="checkbox"/> VT Legal Aid Services	<input type="checkbox"/>
<input type="checkbox"/> NONE OF THE ABOVE	
5a. Housing Programs	5b. Want to Apply (✓)
<input type="checkbox"/> Assistive Community Care Services (ACCS)	<input type="checkbox"/>
<input type="checkbox"/> Housing and Supportive Services (HASS)	<input type="checkbox"/>
<input type="checkbox"/> Section 8 Voucher (Housing Choice)	<input type="checkbox"/>
<input type="checkbox"/> Subsidized Housing	<input type="checkbox"/>
<input type="checkbox"/> NONE OF THE ABOVE	
6a. PATH Benefit Programs	6b. Want to Apply (✓)
<input type="checkbox"/> Aid to Needy Families with Children	<input type="checkbox"/>
<input type="checkbox"/> Essential Persons Program	<input type="checkbox"/>
<input type="checkbox"/> Food Stamp Program	<input type="checkbox"/>
<input type="checkbox"/> Fuel Assistance Program	<input type="checkbox"/>
<input type="checkbox"/> General Assistance Program	<input type="checkbox"/>
<input type="checkbox"/> Medicaid	<input type="checkbox"/>
<input type="checkbox"/> QMB/SLMB	<input type="checkbox"/>

<input type="checkbox"/> Telephone "Lifeline" Discount	<input type="checkbox"/>
<input type="checkbox"/> VHAP (VT Health Access Program)	<input type="checkbox"/>
<input type="checkbox"/> VHAP Pharmacy	<input type="checkbox"/>
<input type="checkbox"/> V-Script	<input type="checkbox"/>
<input type="checkbox"/> NONE OF THE ABOVE	
7a. Other Services/Benefits	7b. Want to Apply (✓)
<input type="checkbox"/> Emergency Response System	<input type="checkbox"/>
<input type="checkbox"/> Supplemental Security Income (SSI)	<input type="checkbox"/>
<input type="checkbox"/> Veterans Benefits	<input type="checkbox"/>
<input type="checkbox"/> Weatherization Program (CAP)	<input type="checkbox"/>
<input type="checkbox"/> NONE OF THE ABOVE	

H. "SELF NEGLECT", ABUSE, NEGLECT, AND EXPLOITATION SCREENING

Directions: *The following information may be obtained from the assessor's observation or reports from the individual, involved family, friends or providers (i.e. Home Health Agency, physician, etc.).*

1. Is the individual refusing services and putting him/herself or others at risk of harm?
 - a. Yes
 - b. No
 - c. info. unavailable

2. Is the individual exhibiting dangerous behaviors and putting him/herself or others at risk of harm?
 - a. Yes
 - b. No
 - c. info. unavailable

3. Is the individual making clear, informed decisions about his/her needs and appear to understand the consequences of these decision?
 - a. Yes
 - b. No
 - c. info. unavailable

4. Is there evidence (observed or reported) of suspected abuse, neglect, or exploitation by another person?
 - a. Yes
 - b. No
 - c. info. unavailable

Comments:

◆ Assessor Action ◆

SELF NEGLECT: *If the answer to #1 or #2 is "Yes" and the answer to #3 is "No", the individual may be considered "Self-Neglect". Refer individuals 60 and older to the local Area Agency on Aging if necessary (AAA) (1-800-642-5119). Refer individuals under 60 to Adult Protective Services at 1-800-564-1612.*

If the answer to #1 or #2 is "Yes" and the answer to # 3 is "Yes", consider a "Negotiated Risk" contract between service providers and the individual.

Make other appropriate referrals regarding "dangerous" behaviors. (i.e. legal, psychiatric, medical, behavioral consult, etc.)

ABUSE / NEGLECT / EXPLOITATION: *If the answer to #4 is "Yes", mandated reporters must file a report of abuse, neglect, or exploitation in accordance with Vermont's Adult Abuse Statue (Title 33) within 48 hours to Adult Protective Services at 1-800-564-1612.*

SECTION 2: Supportive Assistance

1. Date: _____ 2. a. Initial Assessment b. Reassessment c. Update

Directions: Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information. If the individual is unable to answer the following questions, obtain information from family/caregiver or legal representative.

The following questions are specifically in regards to unpaid caregivers, such as family, friends, volunteers.

3. Who is the primary unpaid person who usually helps you? (Check one only)
- a. Spouse or significant other d. Friend, neighbor or community member
 - b. Daughter or son e. NONE (If "NONE, go to Section 3: Living Arrangements)
 - c. Other family member
4. How often do you receive help from this person? (Check one only) **Skip if #3 is NONE.**
- a. Several times during day and night e. One to two times per week
 - b. Several times during day f. Less often than weekly
 - c. Once daily g. Unknown
 - d. Three or more times per week
5. What type of help does this person provide? (Mark all that apply) **Skip if #3 is NONE.**
- a. ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
 - b. IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances, transportation)
 - c. Environmental support (housing, home maintenance)
 - d. Psychosocial support (socialization, companionship, recreation)
 - e. Advocates or facilitates individual's participation in appropriate medical care
 - f. Financial agent, power of attorney, or conservator of finance
 - g. Health care agent, conservator of person, or medical power of attorney
 - h. Unknown

6. Record information on primary unpaid caregiver in #3: **Skip if #3 is NONE.**

a. (Name) _____ b. (Relationship) _____ c. (Phone) _____

d. (Address) _____

Question #7 is to be asked of the primary caregiver identified in question #6a.

7. Which of the following areas are affected by your role as a caregiver?
- a. job d. physical health
 - b. finances e. emotional health
 - c. family responsibilities f. other: _____

Comments:

Comments:

◆ Assessor Action ◆

If the individual's living arrangements indicate significant safety or health issues, discuss and make appropriate referral(s) for home repair, cleaning, and/or pest extermination.

SECTION 4: Emotional/Behavioral/Cognitive Status

1. Date: _____ 2. a. Initial Assessment b. Reassessment c. Update

Directions: Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information.

A. EMOTIONAL WELL-BEING

Complete questions #3- 13 only if the individual answered "Yes" to questions #3, 4, or 5 on page 5, Section 1: Intake (Emotional Health).

"I'd like you to think about your moods and feelings in the last month."

3. → Have you felt satisfied with your life? a. Yes b. No c. Sometimes d. No response
 4. → Have you had a change in your sleeping patterns? a. Yes b. No c. Sometimes d. No response
 5. → Have you had a change in your appetite? a. Yes b. No c. Sometimes d. No response
 6. → *Have you often felt depressed, sad or very unhappy? a. Yes b. No c. Sometimes d. No response

*If answer is YES or SOMETIMES to #6, ask the next question. If answer is NO, go to #12.

7. → *Have you thought about harming yourself? a. Yes b. No

*If answer is YES to #7, ask the next questions. If answer is NO, go to #12.

8. → **Do you have a plan? a. Yes b. No
 9. → **Do you have the means to carry out your plan? a. Yes b. No
 10. → **Do you intend to carry this out? a. Yes b. No
 11. → **Have you harmed yourself before? a. Yes b. No

12. Are you currently receiving psychiatric and/or counseling services?
 a. No b. Yes c. info. unavailable

13. If "Yes", are you receiving services: a. At home b. In the community c. both

B. BEHAVIORAL STATUS

Directions: Code "Problem Behavior" and "Behavior Symptom" for each behavior in last 7 days. Information may be gathered from family, caregiver(s) or assessor's observations.

(A) Problem behavior

- 0 = behavior not exhibited
 1 = behavior of this type occurred less than daily
 2 = behavior occurred daily

(B) Behavioral symptom

- 0 = behavior was not present - **OR**- behavior was easily altered
 1 = behavior was NOT easily altered

	(A)	(B)
1. Wandering: moved with no rational purpose, seemingly oblivious to needs or safety		
2. Verbally abusive: others were threatened, screamed at, cursed at		
3. Physically abusive: others were hit, shoved, scratched, sexually abused		

4. Socially inappropriate/disruptive behavior: made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings		
5. Resists care: resisted taking medications/injections, ADL assistance, or eating		

C. COGNITIVE STATUS

Directions: *Information may be gathered from family/caregiver(s) or assessor's observations. Check the one answer for each that best describes the individual's cognitive status.*

1. Memory and use of information:
 - a. Does not have difficulty remembering and using information. Does not require directions or reminding from others.
 - b. Has minimal difficulty remembering and using information. Requires direction and reminding from others 1 to 3 times per day. Can follow simple written instructions.
 - c. Has difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
 - d. Cannot remember or use information. Requires continual verbal reminding.

2. Global confusion:
 - a. Appropriately responsive to environment.
 - b. Nocturnal confusion on awakening.
 - c. Periodic confusion during daytime.
 - d. Nearly always confused.

3. Verbal communication:
 - a. Speaks normally.
 - b. Minor difficulty with speech or word-finding difficulties.
 - c. Able to carry out only simple conversations.
 - d. Unable to speak coherently or make needs known.

4. Cognitive Skills for Daily Decision-Making
 - a. Independent – decisions consistent/reasonable
 - b. Modified independence – some difficulty in new situations only
 - c. Moderately impaired – decision poor/cues/supervision required
 - d. Severely impaired – never/rarely makes decisions

Comments:

◆ **Assessor Action** ◆

****If "YES" to Emotional Well-Being questions #8-10, contact the appropriate local crisis authorities immediately. Discuss other psychiatric and/or mental health counseling services and make appropriate referrals. Make appropriate referrals regarding behavioral/cognitive symptoms as necessary.**

SECTION 5: Health Assessment

1. Date: _____ 2. a. Initial Assessment b. Reassessment c. Update

Directions: Complete this section for Medicaid Waiver, Adult Day, ASP. May also complete if SECTION 1: Intake indicates a need for more information. If the individual is unable to answer the following questions, obtain information from family/caregiver(s), legal representative and/or medical records.

A. DIAGNOSIS/CONDITIONS/TREATMENTS

1. **Diagnosis:** List the primary medical diagnosis for which the individual is receiving services/treatments.

Primary Diagnosis: _____

2. **Other Disease Diagnosis:** Check (✓) only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses.)

Endocrine/Metabolic/Nutritional		x. <input type="checkbox"/> Paraplegia	
a. <input type="checkbox"/> Diabetes mellitus		y. <input type="checkbox"/> Parkinson's disease	
b. <input type="checkbox"/> Hyperthyroidism		z. <input type="checkbox"/> Quadriplegia	
c. <input type="checkbox"/> Hypothyroidism		aa. <input type="checkbox"/> Seizure disorder	
Heart/Circulation		bb. <input type="checkbox"/> Transient ischemic attack (TIA)	
d. <input type="checkbox"/> Arteriosclerotic heart disease		cc. <input type="checkbox"/> Traumatic brain injury	
e. <input type="checkbox"/> Cardiac dysrhythmias		Psychiatric/Mood	
f. <input type="checkbox"/> Congestive heart failure		dd. <input type="checkbox"/> <i>Anxiety disorder</i>	
g. <input type="checkbox"/> Deep vein thrombosis		ee. <input type="checkbox"/> Depression	
h. <input type="checkbox"/> Hypertension		ff. <input type="checkbox"/> Manic depressive/bipolar disease	
i. <input type="checkbox"/> Hypotension		gg. <input type="checkbox"/> Schizophrenia	
j. <input type="checkbox"/> Peripheral vascular disease		Pulmonary	
k. <input type="checkbox"/> Other cardiovascular disease		hh. <input type="checkbox"/> Asthma	
Musculoskeletal		ii. <input type="checkbox"/> Emphysema/COPD	
l. <input type="checkbox"/> Arthritis		Sensory	
m. <input type="checkbox"/> Hip fracture		jj. <input type="checkbox"/> Cataracts	
n. <input type="checkbox"/> Missing limb		kk. <input type="checkbox"/> Diabetic retinopathy	
o. <input type="checkbox"/> Osteoporosis		ll. <input type="checkbox"/> Glaucoma	
p. <input type="checkbox"/> Pathological bone fracture		mm. <input type="checkbox"/> Macular degeneration	
Neurological		Other	
q. <input type="checkbox"/> Alzheimer's disease		nn. <input type="checkbox"/> Allergies	
r. <input type="checkbox"/> Aphasia		oo. <input type="checkbox"/> Anemia	
s. <input type="checkbox"/> Cerebral palsy		pp. <input type="checkbox"/> Cancer	
t. <input type="checkbox"/> Cerebrovascular accident (stroke)		qq. <input type="checkbox"/> Renal failure	
u. <input type="checkbox"/> Dementia other than Alzheimer's disease		rr. <input type="checkbox"/> NONE OF THE ABOVE	
v. <input type="checkbox"/> Hemiplegia/hemiparesis		ss. <input type="checkbox"/> OTHER:	
w. <input type="checkbox"/> Multiple sclerosis		tt. <input type="checkbox"/> OTHER:	

3. **Infections:** Check (✓) all that apply. If none apply, check the NONE OF THE ABOVE box.

- | | |
|--|--|
| a. <input type="checkbox"/> Antibiotic resistant infection | a. <input type="checkbox"/> Sexually transmitted disease |
| b. <input type="checkbox"/> Clostridium difficile | b. <input type="checkbox"/> Tuberculosis |
| c. <input type="checkbox"/> Conjunctivitis | c. <input type="checkbox"/> Urinary tract infection <i>in last 30 days</i> |
| d. <input type="checkbox"/> HIV infection | d. <input type="checkbox"/> Viral hepatitis |
| e. <input type="checkbox"/> Pneumonia | e. <input type="checkbox"/> Wound infection |
| f. <input type="checkbox"/> Respiratory infection | f. <input type="checkbox"/> OTHER: |
| g. <input type="checkbox"/> Septicemia | g. <input type="checkbox"/> NONE OF THE ABOVE |

4. **Problem Conditions:** Check (✓) all problems present in the last 7 days.

- | | |
|---|--|
| a. <input type="checkbox"/> Dehydration | i. <input type="checkbox"/> Syncope (fainting) |
| b. <input type="checkbox"/> Delusions | h. <input type="checkbox"/> Unsteady gait |
| c. <input type="checkbox"/> Dizziness/Vertigo | i. <input type="checkbox"/> Vomiting (recurring) |
| d. <input type="checkbox"/> Edema | j. <input type="checkbox"/> End stage disease, 6 or fewer months to live |
| e. <input type="checkbox"/> Fever | k. <input type="checkbox"/> NONE OF THE ABOVE |
| f. <input type="checkbox"/> Internal bleeding | l. <input type="checkbox"/> OTHER: |
| g. <input type="checkbox"/> Recurrent lung aspirations <i>in last 90 days</i> | m. <input type="checkbox"/> OTHER: |
| h. <input type="checkbox"/> Shortness of breath | |

5. **Medical Treatments:** Check (✓) treatments received during the last 14 days.

- | | |
|--|--|
| a. <input type="checkbox"/> Chemotherapy | i. <input type="checkbox"/> Suctioning |
| b. <input type="checkbox"/> Dialysis | j. <input type="checkbox"/> Tracheostomy Care |
| c. <input type="checkbox"/> IV meds | k. <input type="checkbox"/> Transfusions (specify) |
| d. <input type="checkbox"/> Intake/output | l. <input type="checkbox"/> Ventilator or respirator |
| e. <input type="checkbox"/> Monitoring acute medical condition | m. <input type="checkbox"/> NONE OF THE ABOVE |
| f. <input type="checkbox"/> Ostomy care | n. <input type="checkbox"/> OTHER: |
| g. <input type="checkbox"/> Oxygen therapy | o. <input type="checkbox"/> OTHER: |
| h. <input type="checkbox"/> Radiation | |

6. **Therapies:** Check (✓) all therapies received in last 7 days.

- a. Speech Therapy
- b. Occupational Therapy
- c. Physical Therapy
- d. Respiratory Therapy
- e. NONE OF THE ABOVE

7. Does the individual currently receive at least 45 minutes/day for at least 3 days week of PT or a combination of PT, ST, or OT? a. Yes b. No c. info. unavailable

8. Check (✓) all nutritional issues in the last 7 days. (Mark all that apply)

- | | |
|---|--|
| a. <input type="checkbox"/> Parenteral/IV | f. <input type="checkbox"/> Dietary supplement between meals |
| b. <input type="checkbox"/> Feeding tube | g. <input type="checkbox"/> Plate guard, stabilized built-up utensil, etc. |
| c. <input type="checkbox"/> Mechanically altered diet | h. <input type="checkbox"/> On a planned weight change program |
| d. <input type="checkbox"/> Syringe (oral feeding) | j. <input type="checkbox"/> Oral liquid diet |
| e. <input type="checkbox"/> Therapeutic diet | k. <input type="checkbox"/> NONE OF THE ABOVE |

9. Check (✓) all current high risk factors characterizing this individual. (Mark all that apply)

- a. Smoking
- b. Obesity
- c. Alcohol dependency
- d. Drug dependency
- e. Unknown
- f. Other: _____
- g. NONE OF THE ABOVE

B. PAIN STATUS

1. What is the frequency of pain interfering with individual's activity or movement? Check one.

- a. Individual has **no** pain or pain does **not** interfere with activity or movement
- b. Less often than daily
- c. Daily, but not constantly
- d. All of the time
- e. Info. unavailable

2. Is the individual experiencing pain that is not easily relieved, occurs at least daily, and affects the individual's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

- a. Yes
- b. No
- c. info. unavailable

C. SKIN STATUS

1. **Ulcers:** Code for the highest stage in the last 7 days using the scale below. (0 = none)

- a. Pressure Ulcer- Any lesion caused by pressure resulting in damage of underlying tissue.
- b. Stasis Ulcer – Open lesion caused by poor circulation in the lower extremities.

Stage

Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

Stage 3: A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.

Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

2. **Other Skin Problems:** Check (✓) all that apply during last 7 days.

- a. Abrasions, bruises
- b. Burns (second or third)
- c. Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions)
- d. Rashes (e.g. intertrigo, eczema, drug rash, heat rash, herpes zoster)
- e. Skin desensitized to pain or pressure
- f. Skin tears or cuts (other than surgery)
- g. Surgical wounds
- h. NONE OF THE ABOVE

D. ELIMINATION STATUS

1. Is the individual prone to frequent urinary tract infections (UTI)? a. Yes b. No

2. Does the individual have urinary incontinence?

- a. Yes
- b. No incontinence and no urinary catheter
- c. No incontinence, individual has urinary catheter

****If answer is b. or c., go to question #5.***

3. What is the frequency of urinary incontinence?

- a. less than once weekly
- b. one to three times weekly
- c. four to six times weekly
- d. one to three times daily
- e. four or more times daily

4. When does urinary incontinence occur?

- a. during the day only
- b. during the night only
- c. during the day and night

5. Does the individual have Bowel Incontinence?

- a. Yes
- b. No incontinence and no ostomy
- c. No incontinence, individual has an ostomy

****If answer is b. or c., go to question #8.***

6. What is the frequency of bowel incontinence?

- a. less than once weekly
- b. one to three times weekly
- c. four to six times weekly
- d. one to three times daily
- e. four or more times daily

7. When does bowel incontinence occur?

- a. during the day only
- b. during the night only
- c. during the day and night

8. Has the individual experienced recurring bouts of diarrhea in the last 7 days?

- a. Yes
- b. No

9. Has the individual experienced recurring bouts of constipation in the last 7 days?

- a. Yes
- b. No

Comments:

Name of RN (*print*): _____

Agency: _____

Individual's Initials _____

Signature of RN: _____ Date: _____

LPN completing health assessment (*Adult Day only*): _____

◆ **Assessor Action** ◆

Incorporate Health Assessment issues into the appropriate plan for services. Make appropriate referrals for identified unmet health needs.

SECTION 6: Functional Assessment

1. Date: _____ 2. a. Initial Assessment b. Reassessment c. Update

Directions: Complete for Medicaid Waiver, ASP and Adult Day. Indicate the highest level of ADL and IADL self-performance and support provided in the **last 7 days**. If the individual is unable to answer the following questions, obtain information from family/caregiver(s), service provider(s), and/or assessor's observations.

A. ACTIVITIES OF DAILY LIVING (ADL's)

KEY (A) = ADL Self Performance (during the last 7 days)

0 =	INDEPENDENT	No help or oversight –OR– help/oversight provided only <u>1 or 2 times</u>
1 =	SUPERVISION	Oversight, encouragement or cueing provided <u>3 or more times</u> –OR– Supervision (3 or more times) <u>plus</u> limited physical assistance provided only <u>1 or 2 times</u>
2 =	LIMITED ASSIST	Individual highly involved in activity, received physical help in guided maneuvering of limbs, or other <u>non-weight bearing</u> assistance <u>3 or more times</u> –OR– Limited assistance (3 or more times) <u>plus</u> extensive assistance provided only <u>1 or 2 times</u>
3 =	EXTENSIVE ASSIST	While individual performed part of activity, weight-bearing support or full caregiver performance <u>3 or more times</u>
4 =	TOTAL DEPENDENCE	Full caregiver performance of activity <u>each time the activity occurred</u> during <u>last 7 days</u>
8 =	DID NOT OCCUR/UK	Activity <u>did not occur</u> (as defined) in last 7 days –OR– Unknown

UNMET NEED: *If the individual DID NOT receive assistance with an activity, yet clearly needs assistance, score according to their actual level of self-performance in the last week and check "Unmet Need". Briefly describe the circumstances in the comments space provided.*

(B) = ADL Support Provided

- 0 = No setup or physical help
- 1 = Setup help only
- 2 = One person physical assist

- 3 = Two+ persons physical assist
- 8 = Activity did not occur during entire 7 days –OR– Unknown

ADL's	(A) Self-Performance	(B) Support Provided
<p>1. Dressing: Putting on, fastening, and taking off all items of clothing, including donning/removing prosthesis.</p> <p><input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>2. Bathing: Taking a full-body bath/shower, sponge bath, including transferring in/out of tub/shower. <u>Score to the highest level of self-performance regardless of frequency of bathing.</u></p> <p><input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>3. Personal Hygiene: Combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers).</p> <p><input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>4. Bed Mobility: Moving to and from lying position, turning side-to-side, and positioning body <u>while in bed.</u></p> <p><input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>5. Toilet Use: Using the toilet, commode, bedpan, urinal; transferring on/off toilet, cleansing self, managing incontinence pad(s), managing ostomy or catheter, adjusting clothes.</p> <p><input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		

6. Adaptive Devices: Putting on and/or removing braces, splints, and other adaptive devices.

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Unmet Need *Comments:*

7. Transferring: Moving between surfaces – to/from: bed, chair, wheelchair, standing position (EXCLUDES to/from bath/toilet)

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Unmet Need *Comments:*

8. Mobility: Moving between locations in his/her home. If in wheelchair, self-sufficiency once in wheelchair.

--	--

Unmet Need *Comments:*

9. Eating: Ability to eat and drink (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition).

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Unmet Need *Comments:*

B. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL's)

KEY (A) = IADL Self Performance

0 =	INDEPENDENT	(With/without assistive devices)—No help provided
1 =	DONE WITH HELP	Individual involved in activity with help, including supervision, reminders, and/or physical help is provided.
2 =	DONE BY OTHERS	Full performance of the activity is done by others. The individual is not involved at all when the activity is performed.
8 =	DID NOT OCCUR/DK	Activity <u>did not occur</u> in last 7 days –OR– Unknown

UNMET NEED: *If the individual DID NOT receive assistance with an activity, yet clearly needs assistance, score according to their actual level of self-performance in the last week and check "Unmet Need". Briefly describe the circumstances in the comments space provided.*

(B) = IADL Support Provided

- 0** = No support provided
- 1** = Supervision/Cueing
- 2** = Set-up only

- 3** = Physical assistance
- 8** = Activity did not occur during entire 7 days **–OR–** Unknown

IADL's	(A) Self- Performance	(B) Support Provided
<p>1. Phone Use: Answering the phone, dialing numbers, and effectively using the telephone to communicate. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>2. Meal Prep: Planning and preparing light meals or reheating delivered meals. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>3. Medications: Preparing and taking all prescribed <u>and</u> over the counter medications reliably and safely, including the correct dosage at appropriate times/intervals. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>4. Money Manage: Payment of bills, managing checkbook/account(s), being aware of potential exploitation, budgets, plans for emergencies, etc. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>5. Household Maintenance: Household maintenance chores such as washing windows, shoveling snow, taking out the garbage and scrubbing floors. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>6. Housekeeping: Housekeeping tasks such as dusting, sweeping, vacuuming, dishes, light mop, and picking up. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>7. Laundry: Carrying laundry to and from the washing machine, using washer and dryer, washing small items by hand. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		

<p>8. Shopping: Planning, selecting, and purchasing items in a store and carrying them home or arranging delivery. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>9. Transportation: Safely using a car, taxi, or public transportation. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>10. Care of Equip: Cleaning, adjusting or general care of adaptive/medical equipment such as wheelchairs, walkers, nebulizer, IV equipment etc. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>11. Child Care: (ASP only) Bathing, dressing and feeding of <u>own</u> child/children (to the extent that the dependent child cannot perform the tasks for him/herself). <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>12. Sup. Animals: (ASP only) Feeding, grooming and a minimum of walking of seeing-eye dogs, hearing-ear dogs, or other support animals. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		
<p>13. Mob. Guide: (ASP only) For individuals who are blind or visually impaired, the ability to get from place to place in and around the home, shopping, and in medical or educational facilities. <input type="checkbox"/> <i>Unmet Need</i> <i>Comments:</i></p>		

◆ Assessor Action ◆

If an "unmet need" has been identified, arrange for appropriate services and review functional assessment and services as needed.

APPENDIX B

APPENDIX B

APPENDIX B
VERMONT LONG TERM CARE CLINICAL ELIGIBILITY CRITERIA
HIGHEST NEED GROUP

Step 1

- A. IF NURSING FACILITY CARE** is the individual's choice, use PASARR screen. If the PASARR screen resulted in a determination that the individual may need active mental health treatment, **stop** and contact the Department of Developmental Disabilities and Mental Health for a Step II PASARR Screen. **If no, continue to Step 2.**
- B. IF HOME AND COMMUNITY-BASED CARE** is the individual's choice, use the HCB screen on the back of this page. If the answer to any question leads to "STOP", the individual is not eligible for the Highest Need group. **If the individual passes all screening questions, proceed to Step 2.**

Step 2

Does the individual require extensive or total assistance with one or more of the following Activities of Daily Living (ADL): Toileting; Eating; Bed Mobility; and Transfer, and limited assistance in any other ADL?

If yes, individual is eligible for the highest need Long Term Care (LTC) Group. If no, proceed to Step 3.

Step 3

Does the individual have a severe impairment with decision making skills **or** a moderate impairment with decision making skills **and** one of the following behavioral symptoms/conditions that is not easily altered?

Wandering	Physical abuse	Resists Care
Verbal Abuse	Inappropriate Behavior	

If yes, individual is eligible for the highest need LTC Group. If No, proceed to Step 4.

Step 4

Does the individual have any of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis?

Stage 3 or 4 Skin Ulcers	2 nd or 3 rd Degree Burns	Ventilator/ Respirator
IV Medications	Parenteral Feedings	Naso-gastric Tube Feeding
End Stage Disease	Suctioning	

If yes, individual is eligible for the highest need LTC Group. If No, proceed to Step 5.

Step 5

Does the individual have an unstable medical condition that requires skilled nursing assessment, monitoring and care on a daily basis related to conditions or treatments including but not limited to the following?

Dehydration	Respiratory Therapy	Gastric Tube Feeding
Internal Bleeding	Septicemia	Quadripalegia
Aphasia	Pneumonia	
Transfusions	Cerebral Palsy	
Vomiting	Multiple Sclerosis Open	
Complex Wounds	Chemotherapy	
Aspirations	Tracheostomy	
Oxygen	Radiation Therapy	

If yes, individual is eligible for the highest need LTC Group.

IF NO, THE INDIVIDUAL IS NOT ELIGIBLE FOR THE HIGHEST NEED LTC GROUP.

Home and Community-Based Pre-Eligibility Screen

1. Is the applicant a Vermont resident and age 18 or over?
 Yes No ***IF NO, STOP.***
2. Is the applicant at least 65 years of age, or does she/he have a physical disability?
 Yes No ***IF NO, STOP.***
3. Is the applicant eligible for (or will be applying for) Long-Term Care Medicaid?
 Yes No ***IF NO, STOP.***
4. Does the applicant demonstrate a primary need for services due to a mental illness or developmental disability?
 Yes No ***IF YES, STOP.***
5. Can the needs of the applicant be met with services other than the 1115 Waiver services (e.g. Medicare or Medicaid services)?
 Yes No ***If YES, STOP.***
6. (a). Is the applicant currently participating in Hospice services and planning to continue these services?
 Yes No *(If yes, answer 6b.)*
(b). If “Yes”, is the applicant eligible for a variance to participate in both the 1115 waiver services and Hospice?
 Yes No ***IF NO, STOP.***
7. Is the applicant currently receiving services under a 1915(c) Medicaid HCBS Waiver and planning to continue these services?
 Yes No ***If YES, STOP.***
8. (a). Is the applicant currently receiving services under the Attendant Services Program and planning to continue these services?
 Yes No *(If yes, answer 8b.)*
(b). If “Yes”, is the applicant eligible for a variance to participate in both the 1115 waiver services and the Attendant Services Program?
 Yes No ***IF NO, STOP.***
9. Can the applicant’s health and welfare be adequately ensured under the 1115 Waiver Program?
 Yes No ***IF NO, STOP.***
10. If the applicant is currently living in an institution, is there a reasonable expectation that housing can be found?
 Yes No ***IF NO, STOP. IF YES,***

CONTINUE WITH CLINICAL ELIGIBILITY SCREENING (PAGE 1)

NOTE: If any of the answers to the questions above led to a “STOP”, then the applicant does not meet the “pre-screening” eligibility criteria for Home-Based 1115 waiver services.

APPENDIX C

APPENDIX C

Current Nursing Home Level of Care Guidelines

Access to publicly funded nursing home services and Medicaid Waiver services is limited to those individuals who meet the eligibility criteria for nursing home care, as set forth by the Department of Aging and Disabilities' Division of Licensing and Protection, via the local Medicare Certified Home Health Agencies. The following Nursing Home Level of Care Guidelines have been used for over twenty years to determine if nursing home placement is necessary and appropriate for an individual. Because each individual is unique, no set of guidelines can encompass all variables to be considered when determining level of care. Nursing facilities and the DA&D Medicaid Waiver program each have additional criteria for admission.

REQUIREMENTS (A, B and C must all be met):

A. The individual must require at least one service on a daily basis including care and/or rehabilitation. An aggregate of different services, as outlined in I, II, and III below, adding up to a 7 day per week basis, is acceptable.

B. Such care (A, above) is most effectively provided in a nursing home or through DA&D Medicaid Waiver services. The individual may meet standards for continued eligibility if evidence in the individual's case record shows that the individual's health condition will worsen if s/he is required to leave the nursing home or if DA&D Medicaid Waiver services are discontinued. Such evidence must include documentation of previous unsuccessful discharge attempts or written consultation reports and attending physician opinions.

C. Assessment for health services needed, care planning, evaluation and monitoring of an individual's response to care and treatment is necessary and conducted by a registered nurse.

I. CARE AND SERVICES

The individual must require at least one service on a daily basis (A, above). a. Activities of Daily Living (ADLs):

Bathing..... Moderate to total assistance required in the act of washing.
Does not include assistance getting in or out of the tub.

Bowel and bladder function.....Frequent incontinence of bowel and/or bladder.

Dressing..... Moderate to total assistance required.

Eating.....Must be fed or require more than encouragement to sustain adequate intake. Set-up assistance or cutting food is not included.

Ambulation.....Physical assistance to walk.

Transferring.....Physical assistance to move from bed to chair or from one surface to another.

b. Rehabilitation.....Skilled teaching required to regain control, function in ADLs; gait training, speech, range of motion, bowel and bladder training.

NOTE:

An individual who is assessed as requiring moderate to total assistance in ADLs will have MDS assessment (or Medicaid Waiver assessment) ADL codes of 3 or 4. Individuals who need lower levels of assistance may also be eligible, based on a combination of personal care and/or health factors.

II. CONDITIONS AND TREATMENTS

The presence of one or more of the following conditions and treatments may qualify an individual for nursing home care or for DA&D Medicaid Waiver services.

- Intravenous fluids/Intravenous medications.....Any need.
- Medication injections.....Frequent titration, regulation or monitoring required for unstable medical condition.
- Pain management.....Daily severe pain.
- Pressure sores.....Stage III, IV, or multiple Stage II pressure sores.
- Airway suctioning.....Any need.
- Tube feedings.....Any nasogastric or new gastric feedings.
- Ventilator or respirator.....Any need.
- Wound care.....Application of dressings involving prescription medication and aseptic techniques for open wounds which may be infected or draining.

III. PSYCHOSOCIAL FACTORS

Within the limits of PASARR and OBRA, psychosocial factors are considered. Psychosocial factors will be considered as justification for nursing home care services if the individual requires 24-hour care in order to meet health needs or if there is a determination that the individual's health will worsen if required to leave the nursing home facility or if DA&D Medicaid Waiver services are discontinued.

- Cognition.....Impaired judgment and/or confusion, which requires constant or frequent direction with ADLs.
- Behavioral symptoms.....Constant or frequent wandering, aggression, and/or inappropriate behavior, which requires controlled environment to maintain safety.

APPENDIX D

APPENDIX D

VERMONT ASSISTED LIVING RESIDENCE AND RESIDENTIAL CARE HOME ASSESSMENT TOOL

NAME OF RESIDENCE: _____

Date of Assessment: (Point of reference for all coding): _____

Amended Assessment (for significant change in condition): _____ / _____ / _____

(For any noted changes within 21 days of initial assessment)

SECTION A: DEMOGRAPHIC INFORMATION

1. Resident Name: _____
2. Gender: Female Male 3. Date of Birth: _____ / _____ / _____
4. Social Security #: _____ 5. Date of Admission: _____ / _____ / _____
6. Medicare/Medicaid #: _____ 7. Other Insurance: _____
8. Physician: _____ 9. Physician's Phone: _____

10. Marital Status: Married Single Divorced Widowed
11. Admitted from: Private home or apartment with home health services
- Private home or apartment without home health services
- Senior housing Hospital Assisted Living Residence
- Nursing Home Residential Care Home Other _____

12. If admitted from hospital, previous or primary residence was (list type of residence from those listed above in #11) _____

13. Name of contact person: _____ Relationship: _____
- Address: _____
- Home Phone: _____ Work Phone: _____
- Name of second contact : _____ Relationship: _____
- Address: _____
- Home Phone: _____ Work Phone: _____

14. Does the resident have (*check all that apply*):
- Resident responsible for self
- Case Manager Name: _____ Phone: _____
- Agency: _____
- Legal Guardian Name: _____ Phone: _____
- Address: _____
- Other Legal Oversight Name: _____ Phone: _____
- Address: _____
- Durable Power of Attorney/Health Care
- Name: _____ Phone: _____
- Address: _____
- Durable Power of Attorney/Financial
- Name: _____ Phone: _____
- Address: _____
- Family Member/Friend Involved
- Name: _____ Phone: _____
- Address: _____
- Copy of forms in resident's file.

Date of Hospitalization: Date of Return: Hospital Admitted to:	Date of Hospitalization: Date of Return: Hospital Admitted to:
Date of Hospitalization: Date of Return: Hospital Admitted to:	Date of Hospitalization: Date of Return: Hospital Admitted to:

15. Check any of the following that apply:
- Living Will Do not hospitalize Autopsy request Do not resuscitate
- Organ donation Feeding restrictions (please list) _____
- Medication restrictions (please list): _____
- Other treatment restrictions (please list): _____
- None of the above
16. Reason for assessment:
- Admission Significant change Annual/Semi-annual assessment
- Other (specify): _____
17. Does the resident have allergies?
- Food: Yes No Medication: Yes No
18. Lifetime occupation(s): _____
19. Religious preference: _____
20. Funeral arrangements: _____

SECTION AC: CUSTOMARY ROUTINE

Complete at initial admission only.

Check all that apply. If all information UNKNOWN, check last box only.

Cycle of Daily Events

- A. Stays up late at night (e.g. after 9 p.m.)
- B. Naps regularly during day (at least 1 hour)
- C. Goes out 1+ days a week
- D. Stays busy with hobbies, reading, or fixed daily routine
- E. Spends most of time alone or watching TV
- F. Moves independently indoors (with appliances, if used)
- G. Use of tobacco products at least daily
- H. NONE OF ABOVE

Eating Patterns

- I. Distinct food preferences
- J. Eats between meals all or most days
- K. Use of alcoholic beverage(s) at least weekly
- L. Eats less than three meals per day. If yes, indicate how many meals taken per day: _____
- M. NONE OF ABOVE

ADL Patterns

- N. In bedclothes much of day
- O. Wakens to toilet all or most nights
- P. Has irregular bowel movement pattern
- Q. Showers for bathing
- R. Bathing in PM
- S. NONE OF ABOVE

Involvement Patterns

- T. Daily contact with relatives/close friends
- U. Usually attends church, temple, synagogue (etc.)
- V. Finds strength in faith
- W. Daily animal companion/presence
- X. Involved in group activities
- Y. NONE OF ABOVE
- Z. UNKNOWN—Resident/family unable to provide information

SECTION B: COGNITIVE PATTERNS

A. Memory (Recall or what was learned or known)

- a. Short-term memory OK : seems/appears to recall after 5 minutes. OK Problems
b. Long-term memory OK: seems/appears to recall long past. OK Problems

B. Memory/Recall Ability (Check all that resident was normally able to recall during last 7 days)

- a. Current season b. Location of own room c. Staff names/faces
d. Current residence e. NONE OF ABOVE are recalled

C. Cognitive Skills for Daily Decision-Making (Made decisions regarding tasks of daily life)

- a. Independent—decisions consistent/reasonable
b. Modified independence—some difficulty in new situations only
c. Moderately impaired—decision poor/cues/supervision required
d. Severely impaired—never/rarely makes decisions

D. Indicators of Delirium

- a. Easily distracted (e.g. difficulty paying attention; gets sidetracked)
b. Periods of altered perception or awareness of surroundings (e.g. moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. Episodes of disorganized speech (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. Periods of restlessness (e.g. fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. Periods of lethargy (e.g. sluggishness; staring into space; difficult to arouse; little body movement)
f. Mental function varies over the course of the day (e.g. sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
g. NONE OF ABOVE

E. Change in Cognitive Status (Resident's cognitive status, skills, or abilities have changed in the last 90 days or since the last assessment)

- a. No change b. Improved c. Deteriorated d. First assessment

SECTION C: COMMUNICATION/HEARING PATTERNS

1. Hearing Patterns

- A. Hears adequately (normal talk, TV, phone)
B. Minimal difficulty (when not in quiet setting)
C. Hears in special situations only (speaker has to adjust tonal quality and speak distinctly)
D. Highly impaired (absence of usual hearing)

2. Communication Devices/Techniques

- A. Hearing aid present and used
B. Hearing aid present and not used regularly
C. Other receptive communication techniques used (e.g. lip reading)
D. NONE OF ABOVE

3. Modes of Expression

- A. Speech
B. Writing messages to express or clarify needs
C. American sign language or Braille
D. Signs/gestures/sounds

- E. Communication board

- F. Other _____
 G. NONE OF ABOVE

4. Making Self Understood

- A. Understood
 B. Usually understood (difficulty finding words or finishing thoughts)
 C. Sometimes understood (ability is limited to making concrete requests)
 D. Rarely/Never understood

5. Ability to Understand

- A. Understands
 B. Usually understands (May miss part/intent of message)
 C. Sometimes understands (Responds to simple/direct communication)
 D. Rarely/Never understands

SECTION D: VISION PATTERNS

Ability to see in adequate light and with glasses if used.

- A. Adequate (sees fine detail, including regular print in newspapers/books)
 B. Impaired (sees large print, but not regular print in newspapers/books)
 C. Moderately impaired (limited vision; not able to see newspaper headlines, but can identify objects)
 D. Highly impaired (object identification in question, but eyes appear to follow objects)
 E. Severely impaired (no vision or sees only light, colors, or shapes; eyes do not appear to follow objects)
 F. If resident uses glasses, is resident able to get his/her glasses without assistance? Yes No

SECTION E: MOOD AND BEHAVIOR PATTERNS

1. Indicators of Depression, Anxiety, Sad Mood

(Record the appropriate code listed below for the frequency of each symptom observed in last 30 days or since admission, irrespective of assumed cause. List a 0,1, or 2 for each question listed in A-P below.)

- 0=Not exhibited in last 30 days
 1=This type exhibited up to 1-5 days a week
 2=This type exhibited daily or almost daily (6-7 days/week)

VERBAL EXPRESSIONS OF DISTRESS

- A. ____ Resident made negative statement
 B. ____ Repetitive questions
 C. ____ Repetitive verbalizations
 D. ____ Persistent anger with self or others
 E. ____ Self-deprecation
 F. ____ Expressions of fears that appear to be unrealistic
 G. ____ Recurrent statement that something terrible is about to happen
 H. ____ Repetitive health complaints
 I. ____ Repetitive anxious complaints/concerns

SLEEP-CYCLE ISSUES

- J. ____ Unpleasant mood in morning
 K. ____ Insomnia/change in usual sleeping pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

- L. ____ Sad, pained, worried facial expressions
 M. ____ Crying, tearfulness
 N. ____ Repetitive physical movement

LOSS OF INTEREST

- O. ____ Withdrawal from activities of interest

P. _____ Reduced social interaction

2. Mood Persistence

One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to “cheer up”, console, or reassure the resident over the last 7 days. **(Circle correct answer)**

- 0. No mood indicators
- 1. Indicators present, easily altered
- 2. Indicators present, not easily altered

3. Behavioral Symptoms

(IF ANY OF THE ANSWERS BELOW ARE CODED a 1 OR a 2, COMPLETE SUPPLEMENT FOR BEHAVIOR AND COGNITION, pages 19 – 20.)

Problem behavior (code for behavior in last 7 days)

- 0 = behavior not exhibited
- 1 = behavior of this type occurred less than daily
- 2 = behavior occurred daily

- A. Wandering (moved with no rational purpose, seemingly oblivious to needs or safety) _____
- B. Verbally abusive (others were threatened, screamed at, cursed at) _____
- C. Physically abusive (others were hit, shoved, scratched, sexually abused) _____
- D. Socially inappropriate/disruptive behavior (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) _____
- E. Resists care (resisted taking medications/injections, ADL assistance, or eating) _____

3. Change in Behavioral Symptoms

Resident's behavior as compared to last assessment:

- No change Improved Deteriorated N/A (initial assessment)

4. Mental Health History

- A. Does the resident have a current diagnosis for: Mental illness Mental retardation None
- B. Does the resident receive services from: Psychologist Private psychiatrist Mental health center
 None Other _____

If the answer to 4A and 4B above are NONE, skip the next 4 items 4C through 4F.

- C. Does the resident go to appointments at the mental health center? Yes No How often? _____
- D. Does the resident attend: Day treatment (MH) Day program (MR) # days/week: 1 2-5
- E. Does the resident take medication for a MI/MR condition? Yes No
- F. If yes, who prescribes the medication? Name: _____ Phone: _____

5. Psychiatric Hospital Stays

Record the number of times resident was admitted with an overnight stay to a psychiatric hospital or psychiatric unit of a hospital in the last 12 months (or since the last assessment if less than one year). Enter 0 if no hospital admissions. _____

SECTION F: PSYCHOSOCIAL WELL-BEING

1. Sense of Initiative/Involvement (*Check all that apply*)

- A. At ease interacting with others
- B. At ease doing planned or structured activities
- C. At ease doing self-initiated activities
- D. Establishes own goals
- E. Pursues involvement in life of residence (e.g. involved in group activities; responds positively to new activities; assists at religious services)
- F. Accepts invitations into most group activities
- G. NONE OF ABOVE

2. Unsettled Relationships (*Check all that apply*)

- A. Covert/open conflict with or repeated criticism of staff
- B. Unhappy with roommate
- C. Unhappy with residents other than roommate
- D. Openly expresses conflict/anger with family
- E. Absence of personal contact with family/friend
- F. Recent loss of close family member/friend
- G. Does not adjust easily to change in routines
- H. NONE OF ABOVE

3. Past Roles (*Check all that apply*)

- A. Strong identification with past roles and life
- B. Expresses sadness/anger/empty feeling over lost roles/status
- C. Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community
- D. NONE OF ABOVE

SECTION G: PHYSICAL FUNCTIONING

1. (A) ADL Self-Performance (Code for resident's performance over all shifts during last 7 days-Not including setup. Code for the most dependent in a 24 hour period.)

- 0 = Independent: No help or oversight OR Help/oversight provided only 1 or 2 times during last 7 days
- 1 = Supervision: Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
- 2 = Limited Assistance: Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other non-weight bearing assistance 3 or more times—OR—More help provided only 1 or 2 times during last 7 days
- 3 = Extensive Assistance: While resident performed part of activity, over last 7 day period, help of following type(s) provided 3 or more times: Weight bearing support; Full staff performance during part (but not all) of last 7 days
- 4 = Total Dependence: Full staff performance of activity during entire 7 days

Code an N/A for Climbs Stairs Only if facility does not have stairs

(B) ADL Support Provided (Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)

0 = No setup or physical help from staff 1 = Setup help only 2 = One person physical assist 3 = Two+ persons physical assist	Self- Performanc	Support
a. BED MOBILITY: how resident moves and positions self		
b. TRANSFER: how resident moves between surfaces		
c. WALK IN ROOM: how resident walks between locations in his/her room		
d. WALK IN CORRIDOR: how resident walks in corridor or in residence		
e. LOCOMOTION IN RESIDENCE: how resident moves between locations in his/her room and adjacent corridor on same floor		
f. LOCOMOTION OUT OF RESIDENCE: how resident moves to and returns from out of residence locations (e.g. areas set aside for dining activities, or treatment). If residence has only one floor, how resident moves to and from distinct areas on the floor		
g. DRESSING: how resident puts on, fastens, and takes off all items of street clothing including donning/removing prosthesis		
h. EATING: how resident eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)		
i. TOILET USE: how resident uses the bathroom (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothing		
j. PERSONAL HYGIENE: how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
k. CLIMBS STAIRS: how resident climbs stairs		
l. BATHING: how resident takes full body bath/shower		

2. Body Control

- A. Bedfast all or most of the time
- B. Quadriplegia
- C. Unsteady gait
- D. Hemiplegia/hemiparesis (weakness/paralysis of 1 side)
- E. Amputation
- F. NONE OF ABOVE

3. Modes of Locomotion

- A. Cane/walker/crutch C. Wheelchair primary mode of locomotion E. NONE OF ABOVE
 B. Wheeled self D. other person wheeled

4. Modes of Transfer

- A. Bedfast all or most of the time D. Transfer aid (e.g. slide board, trapeze, cane, walker, brace)
 B. Lifted manually
 C. Bed rails used for bed mobility or transfer E. Lifted mechanically
 D. NONE OF ABOVE

5. Self-Performance in ADLs (*Resident's ADL status or abilities compared to last assessment*).

- No change Improved Declined N/A First assessment

5A. IADL Self-Performance

(If questions within the shaded areas of the ADL Section G, Physical Functioning Page 7 are coded a 3 or 4, completion of this section is optional.)

Code for level of independence in the last 30 days based on resident's involvement in the activity.

A. Self-Performance Codes:

- 0 = Independent: (With/without assistive devices)—No help provided.
 1 = Done with help: Resident involved in activity with help, including supervision, reminders, and/or physical help is provided.
 2 = Done by others: Full performance of the activity is done by others. The resident is not involved at all when the activity is performed.

B. Performance Support Codes:

- 0 = No support provided
 1 = Supervision/cueing provided
 2 = Set-up only is provided
 3 = Physical assistance is provided
 4 = Total dependence: The resident is not involved at all when the activity is performed

IADL	Self-Performance	Performance Support
a. Resident arranges for shopping for clothing, snacks or other incidentals.		
b. Resident shops for clothing, snacks, or other incidentals.		
c. Resident arranges suitable transportation.		
d. Resident manages finances: banking, handling checkbook, or paying bills.		
e. Resident manages cash, personal needs allowance.		
f. Resident prepares snacks, light meals.		
g. Resident uses phone.		
h. Resident does light housework, e.g. makes bed, dusts, or takes care of belongings.		

5B. Transportation

(Check all that apply for the level of independence in the last 30 days based on resident's involvement in the activity.)

- A. Resident drove car or used transportation independently to get to medical, dental appointments, necessary engagements or other activities.

- B. Resident rode to destination with staff, family, others (in car, van, public transportation) but was not accompanied to medical or dental appointments, necessary engagements, or other activities.
- C. Resident rode to destination with staff, family, others (in car, van, public transportation) and was accompanied to medical or dental appointments, necessary engagements, or other activities.
- D. Activity did not occur.

6. ADL and IADL Functional Rehabilitation or Improvement Potential *(Check all that apply)*

- A. Resident believes he/she is capable of increasing independence on at least some ADLs or IADLs.
- B. Direct care staff believe resident is capable of increased independence in at least some ADLs or IADLs.
- C. Resident able to perform tasks/activity but is very slow.
- D. Resident's abilities to perform using these activities differ or vary from morning to evening.
- E. Resident requires or only understands a one-step direction.
- F. Resident requires or only understands no more than a two-step direction.
- G. Resident could be more independent if he/she had special equipment (e.g. cane, walker, plate guard).
- H. Resident could perform more independently if some or all of ADL/IADL activities were broken into subtasks (task segmentation).
- I. Resident could be more independent if he/she received ADL or IADL skills training.
- J. NONE OF ABOVE

7. New Devices Needed *(Check all that apply)*

Resident expresses or gives evidence of needing new or additional assistive devices.

- | | |
|---|--|
| A. <input type="checkbox"/> Eyeglasses | F. <input type="checkbox"/> Assistive dressing devices (e.g. button hook, velcro closings) |
| B. <input type="checkbox"/> Hearing aid | G. <input type="checkbox"/> Dentures |
| C. <input type="checkbox"/> Cane or walker | H. <input type="checkbox"/> Other: _____ |
| D. <input type="checkbox"/> Wheelchair | I. <input type="checkbox"/> NONE OF ABOVE |
| E. <input type="checkbox"/> Assistive feeding devices (e.g. plate guard, stabilized built-up utensil) | |

8. Self-Performance in IADLs *(Resident's IADL status or abilities compared to last assessment)*

- No change Improved Declined N/A First assessment

SECTION H: CONTINENCE IN LAST 14 DAYS

1. Bladder Contenance *(Check only one)*

Control of urinary bladder function (if dribbles, volume is insufficient to soak through underpants) with appliances used (e.g. pads or incontinence program employed), in last 7 days.

- CONTINENT: Complete control
- USUALLY CONTINENT: Incontinent episodes once a week or less
- OCCASIONALLY INCONTINENT: 2 or more times a week but not daily
- FREQUENTLY INCONTINENT: Tended to be incontinent daily, but some control present
- INCONTINENT: Inadequate control, multiple daily episodes

2. Bowel Contenance *(Check only one)*

In last 7 days, control of bowel movement, with appliance or bowel continence programs if employed

- CONTINENT: Complete control
- USUALLY CONTINENT: Bowel incontinence episodes less than weekly
- OCCASIONALLY INCONTINENT: Bowel incontinent episodes once a week
- FREQUENTLY INCONTINENT: Bowel incontinent episodes 2 – 3 times a week
- INCONTINENT: Bowel incontinent all (or almost all) of the time

3. Appliances and Programs (Check all that apply)

- A. Any scheduled toileting plan
- B. Bladder retraining program
- C. External (condom) catheter
- D. Indwelling catheter
- E. Intermittent catheter
- F. Did not use bathroom/commode/urinal
- G. Pads/briefs used
- H. Enemas/irrigation
- I. Ostomy present
- J. NONE OF ABOVE

4. Change in urinary continence (Resident's urinary continence has changed as compared to status of 90 days ago or since last assessment if less than 90 days)

- No change Improved Deteriorated N/A First assessment

5. Use of incontinence supplies (Check only one) (Resident's management of incontinence supplies, e.g. pads, briefs, ostomy, catheter in last 14 days.)

- A. Always continent
- B. Resident incontinent and able to manage incontinence supplies independently
- C. Resident incontinent and receives assistance with managing incontinence supplies
- D. Resident incontinent and does not use incontinence supplies

SECTION I. DIAGNOSIS

(Check only those diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nurse monitoring, or risk of death and have been documented in the resident's record.)

Do not list inactive diagnoses. If none apply, check the NONE OF ABOVE box.

ENDOCRINE/METABOLIC/NUTRITION

- A. Diabetes mellitus
- B. Hyperthyroidism
- C. Hypothyroidism

HEART/CIRCULATION

- D. Arteriosclerotic heart disease (ASHD)
- E. Cardiac dysrhythmias
- F. Congestive heart failure
- G. Deep vein thrombosis
- H. Hypertension
- I. Hypotension
- J. Peripheral vascular disease
- K. Other cardiovascular disease

MUSCULOSKELETAL

- L. Arthritis
- M. Hip fracture
- N. Missing limb (e.g. amputation)
- O. Osteoporosis
- P. Pathological bone fracture

NEUROLOGICAL

- Q. Alzheimer's disease
- R. Aphasia
- S. Cerebral palsy
- T. Cerebrovascular accident (stroke)
- U. Dementia other than Alzheimer's disease
- V. Hemiplegia/hemiparesis
- W. Multiple sclerosis
- X. Paraplegia
- Y. Parkinson's disease
- Z. Quadriplegia
- AA. Seizure disorder

- BB. Transient ischemic attacks

- CC. Traumatic brain injury

PSYCHIATRIC/MOOD

- DD. Anxiety disorder
- EE. Depression
- FF. Manic depressive (Bipolar)
- GG. Schizophrenia

PULMONARY

- HH. Asthma
- II. Emphysema/COPD

SENSORY

- JJ. Cataracts
- KK. Diabetic retinopathy
- LL. Glaucoma
- MM. Macular degeneration

OTHER

- NN. Allergies/Adverse reactions (specify)
- OO. Anemia
- PP. Cancer
- QQ. Renal failure
- RR. Tuberculosis-TB
- SS. HIV
- TT. Mental retardation (e.g. Down's syndrome, Autism, other organic condition related to Mental Retardation or Developmental disability)
- UU. Substance abuse (alcohol or drug)
- VV. Other psychiatric diagnosis (e.g. paranoia, phobias, personality disorder)
- WW. Explicit terminal prognosis
- XX. NONE OF ABOVE

INFECTIONS (if none apply check the NONE OF ABOVE box)

- A. HIV Infection
- B. Pneumonia
- C. Respiratory Infection
- D. Septicemia
- E. Urinary tract infection in last 30 days
- F. Wound infection
- G. NONE OF ABOVE

SECTION J: ORAL/NUTRITIONAL STATUS (Check all that apply)

1. Oral Problems

- A. Mouth is "dry" when eating a meal
- B. Mouth pain
- C. Resident has difficulty brushing teeth or dentures
- D. NONE OF ABOVE

2. Height and Weight

Record height in inches and weight in pounds. Base weight on most recent measure in last 30 days, or since last assessment; measure weight consistently in accord with standard Residence practice—e.g. in a.m. after voiding, before meal, with shoes off, and in nightclothes.

Height _____ Weight _____

3. Weight Change

(e.g. 5% or more in a 30 day period or 10% in the past 6 months)

- A. Weight Loss Yes No N/A First assessment
- B. Weight Gain Yes No N/A First assessment

4. Nutritional Problems (In last seven days or since admission)

- A. Chewing or swallowing problem
- B. Complains about the taste of many foods
- C. Regular or repetitive complaints of hunger
- D. Leaves 25% or more of food uneaten at most meals

5. Nutritional Approaches

- A. Parenteral IV
- B. Feeding tube
- C. Syringe (oral feeding)
- D. On a planned weight change program
- E. Therapeutic diet
- F. Mechanically altered (or pureed) diet
- G. Noncompliance with diet
- H. Food allergies (specify) _____
- I. Restrictions (specify) _____
- J. NONE OF ABOVE

SECTION K: ORAL/DENTAL STATUS

- A. Debris (soft, easily movable substances) present in mouth prior to going to bed
- B. Has dentures or removable bridges
- C. Some/all natural teeth lost-does not have or does not use dentures (or partial plates)
- D. Broken, loose, or canous teeth
- E. Inflamed gums (gingival; swollen or bleeding gums; oral abscesses; ulcers or rashes)
- F. Daily cleaning of teeth/dentures or daily mouth care- by resident or staff

G. NONE OF ABOVE

H. **SECTION L: SKIN CONDITION**

1. **Ulcers** (Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record “0” (zero). Code all that apply during last 7 days or since last assessment. Code 9 = 9 or more) (Requires full body exam)

- A. _____ **Stage 1:** A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
- B. _____ **Stage 2:** A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
- C. _____ **Stage 3:** A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue.
- D. _____ **Stage 4:** A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

2. **Type of Ulcer** (For each ulcer, code for the highest stage in the last 7 days or since last assessment using scale in item M1 above—e.g. 0 = none; stages 1,2,3,4)

- A. _____ Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue.
- B. _____ Stasis ulcer—open lesion caused by poor circulation in the lower extremities.

3. **Other Skin Problems or Lesions Present** (Check all that apply during last 7 days or since last assessment)

- A. Abrasions (scrapes)
- B. Burns
- C. Bruises
- D. Rashes, itchiness, body lice, scabs
- E. Open sores or lesions
- F. Skin tears or cuts (other than surgical)
- G. Surgical wounds
- H. NONE OF ABOVE

4. **Foot Problems**

- A. Resident or someone else inspects resident’s feet on a regular basis? Yes No
- B. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, or structural problem? Yes No

5. **Skin Treatments** (Check all that apply in last 7 days)

- A. Pressure relieving device(s) for chair
- B. Pressure relieving device(s) for bed
- C. Turning/positioning program
- D. Nutrition or hydration intervention to manage skin problems
- E. Application of dressings (with or without topical medications) other than to feet
- F. Application of ointments/medications (other than to feet)
- G. Other preventative or protective skin care (other than to feet)
- H. Ulcer care
- I. Surgical wound care
- J. NONE OF ABOVE

If any of the above skin treatments are provided by outside resources (e.g. home health agency, PNS, etc) please list here:

SECTION M: ACTIVITY PURSUIT PATTERNS

1. General Activity Preferences *(Adapted to resident's current abilities)*

(Check all preferences whether or not activity is currently available to resident)

- | | |
|--|---|
| A. <input type="checkbox"/> Cards/other games | J. <input type="checkbox"/> Watching TV |
| B. <input type="checkbox"/> Crafts/arts | K. <input type="checkbox"/> Gardening or plants |
| C. <input type="checkbox"/> Exercise/sports | L. <input type="checkbox"/> Talking or conversing |
| D. <input type="checkbox"/> Dancing | M. <input type="checkbox"/> Helping others |
| E. <input type="checkbox"/> Music | N. <input type="checkbox"/> Doing chores around the house/residence |
| F. <input type="checkbox"/> Reading/writing | O. <input type="checkbox"/> Cooking/baking |
| G. <input type="checkbox"/> Spiritual/religious activities | P. <input type="checkbox"/> Other _____ |
| H. <input type="checkbox"/> Trips/shopping | Q. <input type="checkbox"/> NONE OF ABOVE |
| I. <input type="checkbox"/> Walking/wheeling outdoors | |

2. Preferred Activity Settings *(Check all settings at which activities are preferred.)*

- | | |
|---|---|
| A. <input type="checkbox"/> Own room | D. <input type="checkbox"/> Away from residence |
| B. <input type="checkbox"/> Day/activity room | E. <input type="checkbox"/> NONE OF ABOVE |
| C. <input type="checkbox"/> Outside of the residence (e.g. in yard) | |

3. Interaction with Family and Friends

- A. How often is resident visited by family or friends?
- | | | |
|-------------------------------------|---|--|
| <input type="checkbox"/> No friends | <input type="checkbox"/> Once a week | <input type="checkbox"/> 1-3 times a month |
| <input type="checkbox"/> None | <input type="checkbox"/> 2-3 times a week | <input type="checkbox"/> Daily |
- B. How often does resident talk by telephone with family and friends?
- | | |
|---|---|
| <input type="checkbox"/> No family or friends outside residence | <input type="checkbox"/> Once a week |
| <input type="checkbox"/> None | <input type="checkbox"/> 2-3 times a week |
| <input type="checkbox"/> 1-3 times a month | <input type="checkbox"/> Daily |

4. Voting

- A. Is resident registered to vote? Yes No

5. Social Activities *(Check only one.)*

Resident's current level of participation in social, religious or other personal activities compared to last assessment:

- No change Improved Declined N/A First assessment

SECTION N: MEDICATIONS

- A. Does the resident take medication? Include over the counter medications. Yes No

If yes, answer the next 4 questions. If no, skip to Special Treatments and Procedures.

- B. Does the resident know what the medications are for? Yes No
- C. Does the resident know how to take the medications? (proper route) Yes No
- D. Does the resident know how often to take the medications? Yes No
- E. Does the resident communicate if the medication has had the desired effect or unintended side effects? Yes No

A NO response to any question B. through E. indicates the resident needs medication administration. Inform the registered nurse. Have the nurse review and complete the MEDICATION SECTION.

- F. Does the resident control his/her own prescription medications? Yes No
- G. Does the resident control his/her own over-the-counter medications? Yes No
- H. Injections: Record the # of days injections of any type received during last 7 days. _____

I. Who gives the injections? (*Choose one*)

- Resident
- Residence Nurse
- Home Health
- Other _____

J. When was the last time the physician reviewed ALL the resident's medications? (*Choose one*)

- 1-6 months
- 12 months
- Over 1 year
- Unknown

K. Medication Compliance (*Resident's level of compliance with medications prescribed by a physician/psychiatrist during last 30 days or since admission.*)

- Always compliant
- Compliant some of the time (80% of the time or more often) or with some medications.
- Rarely or never compliant

L. Record the number of days during the last 7 days any of the following medications were used.;
"0" if not used.

- ___ Anti-psychotic
- ___ Anti-anxiety
- ___ Anti-depressant
- ___ Hypnotic
- ___ Diuretic

SECTION O: SPECIAL TREATMENTS AND PROCEDURES

1. Special Treatments, Procedures and Programs

a. SPECIAL CARE—Check treatments or programs received during the last 14 days.

TREATMENTS

- A. Chemotherapy or radiation
- B. Dialysis
- C. IV medication
- D. Intake/output
- E. Monitoring acute medication condition
- F. Ostomy care
- G. Oxygen therapy
- H. Suctioning
- I. Tracheostomy care
- J. Transfusions
- K. Ventilator or respirator

PROGRAMS

- L. Alcohol/drug treatment program
- M. Alzheimer's/dementia special care unit
- N. Hospice care
- O. Home health
- P. Home care
- Q. Training in skills required to return to the community (e.g. taking medications, house work, shopping, transportation, ADLs)
- R. Case management
- S. Day treatment program
- T. Sheltered workshop/employment
- U. Transportation
- V. Psychological rehabilitation
- W. Respite
- X. NONE OF ABOVE

b. **THERAPIES**-- Record the number of days the following therapies were administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 minutes a day)

(A) = # of days administered for 15 minutes or more

Check B if therapy was received at the residence.

Check C if therapy was received out-of- residence.

	DAYS (A)	ON SITE (B)	OFF SITE (C)
a. Speech –language pathology and audiology services			
b. Occupational therapy			
c. Physical therapy			
d. Respiratory therapy			
e. Psychological therapy (by any licensed mental health professional)			

2. Special Programs for Mood, Behavior and Cognitive Loss

- A. Special behavioral symptom management program: a program of ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms. The purpose of such a program is to attempt to understand the “meaning” behind the resident’s behavioral symptoms in relation to the resident’s health and functional status, and social and physical environment. The ultimate goal of the evaluation is to develop and implement a plan of care that serves to reduce distressing symptoms.
- B. Special behavioral management program: includes resident-specific changes in the environment to address mood/behavior/cognitive patterns. Examples include placing a banner labeled “wet paint” across a closet door to keep the resident from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary “props” for a resident who frequently stops wandering to rummage. Reorientation includes individual or group sessions that aim to reduce disorientation in confused residents, including environmental cueing in which all staff involved with the resident provide orienting information and reminders.
- C. Evaluation by a licensed mental health specialist since last assessment: an assessment of a mood, behavior disorder, or other mental health problem by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Do not check this item for routine visits by the residence social worker.
- D. Group therapy: resident regularly attends sessions at least weekly. Therapy is aimed at helping to reduce loneliness, isolation, and the sense that one’s problems are unique and difficult to solve. The session may take place either at the residence or outside the residence.
- E. Other _____
- F. NONE OF ABOVE

3. Rehabilitative/Restorative Care (Record the number of days each of the following rehabilitative or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days). Enter 0 if none or less than 15 minutes daily.

- A. ____ Range of motion (passive)
- B. ____ Range of motion (active)
- C. ____ Splint or brace assistance
- D. ____ Bed mobility
- E. ____ Transfer
- F. ____ Walking
- G. ____ Dressing or grooming
- H. ____ Eating or swallowing
- I. ____ Amputation/prosthesis care
- J. ____ Communication
- K. ____ Other (specify) _____
- L. ____ NONE OF ABOVE

4. Skills Training (Record the number of days, in the last 30 days that each of the following IADLs were performed with assistance from staff as a skill training activity identified in the resident’s service plan.)

SKIP IF THE IADL SECTION, PAGE 8 WAS NOT COMPLETED.

- A. ____ Meal preparation (snacks, light meals)
- B. ____ Telephone use
- C. ____ Light housework (makes own bed, takes care of belongings)

- D. _____ Laundry (sorts, folds, or washes own laundry)
- E. _____ Managing incontinence supplies (pads, briefs, ostomy, catheter)
- F. _____ Managing cash (handles cash, makes purchases)
- G. _____ Managing finances (banking, handling checkbook or savings account)
- H. _____ Arranges shopping (makes list, acquires help)
- I. _____ Shopping (for groceries, clothes, or incidentals)
- J. _____ Transportation (travel by various means to get to appointments or necessary engagements)
- K. _____ Medications (preparation and administration of medications)

5. Preventive Health/Health Behaviors (Check all that the resident received in the past 2 years, if known.)

	Date: Month/Year
A. <input type="checkbox"/> Blood pressure monitoring	_____
B. <input type="checkbox"/> Hearing assessment	_____
C. <input type="checkbox"/> Vision test	_____
D. <input type="checkbox"/> Dental visit	_____
E. <input type="checkbox"/> Influenza vaccine	_____
F. <input type="checkbox"/> Pneumococcal vaccine (anytime)	_____
G. <input type="checkbox"/> Breast exam or mammogram	_____
H. <input type="checkbox"/> Pap smear	_____
I. <input type="checkbox"/> Other	_____

6. Visiting Nurse/Home Health Therapies

Has the resident received care or services from a home health nurse or aide since the last assessment?

Yes No N/A First assessment

If yes, check all that apply:

	Less than once a week	Once a week	More than once/week
Nurse	_____	_____	_____
Nurse aide	_____	_____	_____

7. Devices and Restraints (Codes: 0=not used; 1=used less than daily; 2 = used daily)

- A. _____ Full bed rails on all open sides of bed
- B. _____ Trunk restraint
- C. _____ Other types of side rails, e.g. half, etc.
- D. _____ Chair prevents rising
- E. _____ Limb restraint

SECTION P: DISCHARGE POTENTIAL

- A. Does resident or family indicate a preference for another living arrangement? Yes No
- B. Does resident have a support person who is positive towards discharge? Yes No
- C. Is the stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death) ? Yes No
- D. Has resident' self-sufficiency changed compared to last assessment?
 - No change Improved (receives fewer supports, needs less restrictive plan of care)
 - Deteriorated (receives more support) N/A First assessment

NOTES:

SECTION Q: ASSESSMENT INFORMATION

1. Participation in Assessment

- A. Resident Yes No
B. Family Yes No No family
C. Legal representative Yes No

2. SIGNATURES OF PERSONS COMPLETING ASSESSMENT:

a. Signature of Residence Nurse completing assessment (sign on line below)

b. Signature of Resident or legal representative (sign on line below)

c. Date Residence Nurse signed as complete

 - - -
 Month Day Year

d. Other Signatures

Title

Sections

Date

**ASSISTED LIVING RESIDENCE AND
RESIDENTIAL CARE HOME ASSESSMENT TOOL**

SUPPLEMENTAL BEHAVIOR AND COGNITION INFORMATION

Note: This section is required if the answers on Page 5: Behavioral Symptoms were coded either a (1) or a (2). This section is optional for all other assessments.

This tool is to provide more detailed information for you and formal and informal caregivers about the resident's current cognitive and behavioral status. It will be helpful for staff to have this information before they begin providing services to the resident. This is also a useful tool for determining how the resident's status is changing over time.

BEHAVIOR

Please check the description that most accurately describes the resident's behavior:

1. Sleep Pattern

- Unchanged from "normal" for the resident.
- Sleeps noticeably more or less than "normal".
- Restless, nightmares, disturbed sleep, increased awakenings.
- Up wandering for all or most of the night, inability to sleep.

2. Wandering

- Does not wander.
- Does not wander. Is chair-bound or bed-bound.
- Wanders within the residence any may wander outside but does not jeopardize health and safety.
- Wanders within the residence. May wander outside, health and safety may be jeopardized. Does not have history of getting lost and is not combative about returning.
- Wanders outside and leaves grounds. Has a consistent history of leaving grounds, getting lost or being combative about returning. Requires a treatment plan that may include the use of psychotropic drugs for management and safety.

3. Behavioral demands on others

- Attitudes, habits and emotional states do not limit the individual's type of living arrangement and companions.
- Attitudes, habits and emotional states limit the individual's type of living arrangement and companions.
- Attitudes, disturbances and emotional states create consistent difficulties that are not modifiable to manageable levels. The individual's behavior cannot be changed to reach the desired outcome through respite, existing residence staff, even given staff training.

4. Danger to self and others

- Is not disruptive or aggressive and is not dangerous.
- Is not capable of harming self or others because of mobility limitations (is bed-bound or chair-bound)
- Is sometimes (1-3 times in the last 7 days) disruptive or aggressive either physically or verbally or is sometimes extremely agitated or anxious even after proper evaluation and treatment
- Is frequently (4 or more times during the last 7 days) disruptive or aggressive or is frequently extremely agitated or anxious and professional judgment is required to determine when to administer prescribed medications

Is dangerous or physically abusive and even with proper evaluation and treatment may require physician's orders for appropriate intervention

5. Awareness of needs/Judgments

- Understands those needs that must be met to maintain self-care
- Sometimes (1-3 times in the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation
- Frequently (4 or more times during the last 7 days) has difficulty understanding those needs that must be met but will cooperate when given direction or explanation
- Does not understand those needs that must be met for self-care and will not cooperate even though given direction or explanation

COGNITION

Please check the description that most accurately describes the resident's behavior:

1. Memory for events

- Can recall details and sequences of recent experiences and remember names of meaningful acquaintances
- Cannot recall details or sequences of recent events or remember names of meaningful acquaintances
- Cannot recall entire events (e.g. recent outings, visits of relatives or friends) or names of close friends or relatives without prompting
- Cannot recall entire events or name of spouse or other living partner even with prompting

2. Memory and use of information

- Does not have difficulty remembering and using information. Does not require directions or reminding from others
- Has minimal difficulty remembering and using information. Requires direction and reminding from other 1 to 3 times per day. Can follow simple written instruction.
- Has difficulty remembering and using information. Requires direction and reminding from others 4 or more times per day.
- Cannot remember or use information. Requires continual verbal reminding.

3. Global confusion

- Appropriately responsive to environment.
- Nocturnal confusion on awakening.
- Periodic confusion during daytime.
- Nearly always confused.

4. Spatial orientation

- Oriented, able to find and keep his/her bearings.
- Spatial confusion when driving or riding in local community.
- Gets lost when walking in neighborhood.
- Gets lost in residence or present environment.

5. Verbal communication

- Speaks normally.
- Minor difficulty with speech or word-finding difficulties.
- Able to carry out only simple conversations.
- Unable to speak coherently or make needs known.

APPENDIX E

Current Services outside the Waiver

Note: In some cases, individuals could receive some of these services in addition to 1115 Waiver services.

Home Health services (Medicare, Medicaid, private pay, other insurance)

- MSW
- RN
- LNA
- PT, OT, ST
- Hospice

Older Americans Act

- Information and Referral (the Senior HelpLine)
- Nutrition Programs (Home-delivered meals, congregate meals, nutrition counseling)
- Case management
- Transportation
- National Family Caregiver Support Program
- Local support groups, programs and volunteer connections

Other Services/Programs

- Dementia Respite grants
- Attendant Services Program (Medicaid and GF)
- Veteran's Administration
- Residential Care/Assisted Living (funded through Assistive Community Care Services – Medicaid State Plan)
- Adult Day (Day Health Rehabilitative Services, VA, private pay)
- Senior Centers
- Foster Grandparents
- Senior Companion
- Transportation (5310 program and Medicaid)
- Housing and Supportive Services (HASS) – in Senior Congregate Housing
- Home Access Program (home modifications through the Vermont Center for Independent Living)
- Home-delivered meals for people under age 60 (through the Vermont Center for Independent Living)
- Peer Advocate Counselors (through the Vermont Center for Independent Living)
- RSVP
- Essential Persons Program (PATH)
- Adult Protective Services
- Long-Term Care Ombudsman
- Office of Public Guardian
- Local support groups
- Elder Care clinicians and other mental health services (through community mental health centers)
- Housing subsidies
- Income benefits, e.g. fuel assistance, food stamps

APPENDIX F

2001 Consumer Satisfaction Survey

Executive Summary

Background

As a part of a comprehensive strategy to improve Vermont's system of long-term care, the Department of Aging and Disabilities has crafted partnerships with counties and regions to plan and manage long-term care services available to Vermonters. As a part of these outcome-based partnerships, the Department routinely conducts surveys with consumers to measure satisfaction with systems of care and overall quality of life.

For the third year, the Department contracted with ORC Macro of Burlington, Vermont, to conduct a statewide survey of individuals receiving services from Department-sponsored programs in 2001. The survey was designed to provide objective information about long-term care consumers from different areas around the state, as well as to compare these results to those obtained in 1999 and in 2000. A combination of mail and telephone surveys were conducted with long-term care consumers in the Adult Day, Medicaid Waiver Services, Homemaker, and Attendant Services programs over the age of 18. In addition, results from a series of quality of life questions posed to a representative sample of the general Vermont population (who were not necessarily receiving long-term care services) were compared to the responses of long-term care consumers.

The 2000 and 2001 surveys were identical, and asked consumers about their experiences with the Attendant Services, Homemaker, Medicaid Waiver Services, and Adult Day Programs. However, the 1999 survey asked consumers questions about the Home Delivered Meals Program, rather than the Homemaker Program. Therefore, while 2000 and 2001 results may be directly compared, comparison of 1999 results to those of 2000 and 2001 should be considered general trends.

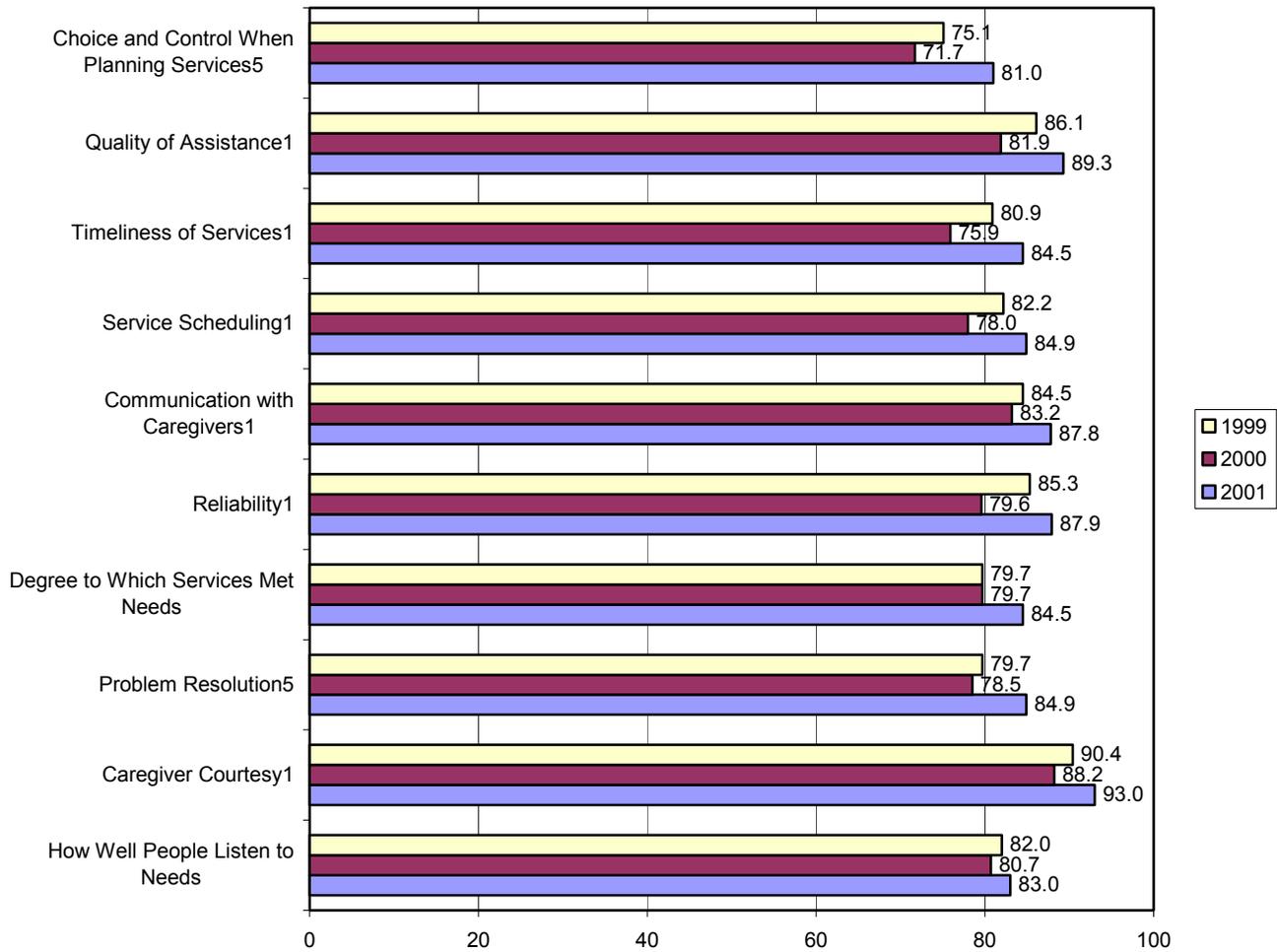
Overall Consumer Satisfaction

Consumers of the State's long-term care services indicated overwhelming satisfaction and approval for the programs in which they participated. Satisfaction and approval ratings were consistently high across all measures. For the third year in a row, consumers were most satisfied with the courtesy shown by their caregivers, with 93% of consumers indicating they felt caregiver courtesy was either "excellent" or "good." Additionally, at least 85% of long-term care consumers statewide indicated similar levels of satisfaction with the quality of assistance they received (89.3%), the reliability of service (87.9%), and communication with caregivers (87.8%).

Long-term care consumers statewide were less satisfied with the amount of choice and control they had when planning their long-term care services, although their satisfaction level increased significantly in 2001 compared to 2000. Whereas only 71.7% of consumers rated the amount of choice and control they had as "excellent" or "good" in 2000, 81.0% rated this service element as "excellent" or "good" in 2001.

In 2001, the percentage of consumers who felt long-term care programs were a good value for the services they received remained consistent with 2000 results, at about 80%. Furthermore, an overwhelming majority (89.1%) of consumers felt the help they have received from long-term care services had made their lives “much” or “somewhat better.” Over 80% of consumers statewide felt it would be “difficult” or “very difficult” to stay in their homes if they did not receive long-term care services.

Percentage of Respondents Statewide Who Rated Overall Services as "Excellent" or "Good"



¹ Indicates statistical difference between 2000 and 2001

² Indicates statistical difference between 1999 and 2001

³ Indicates statistical difference between 1999 and 2000

⁴ Indicates statistical difference between 1999, 2000 and 2001

⁵ Indicates statistical difference between 1999 and 2001 and also 2000 and 2001

⁶ Indicates statistical difference between 1999 and 2000 and also 2000 and 2001

⁷ Indicates statistical difference between 1999 and 2000 and also 1999 and 2001

Quality of Life Among Long-Term Care Consumers

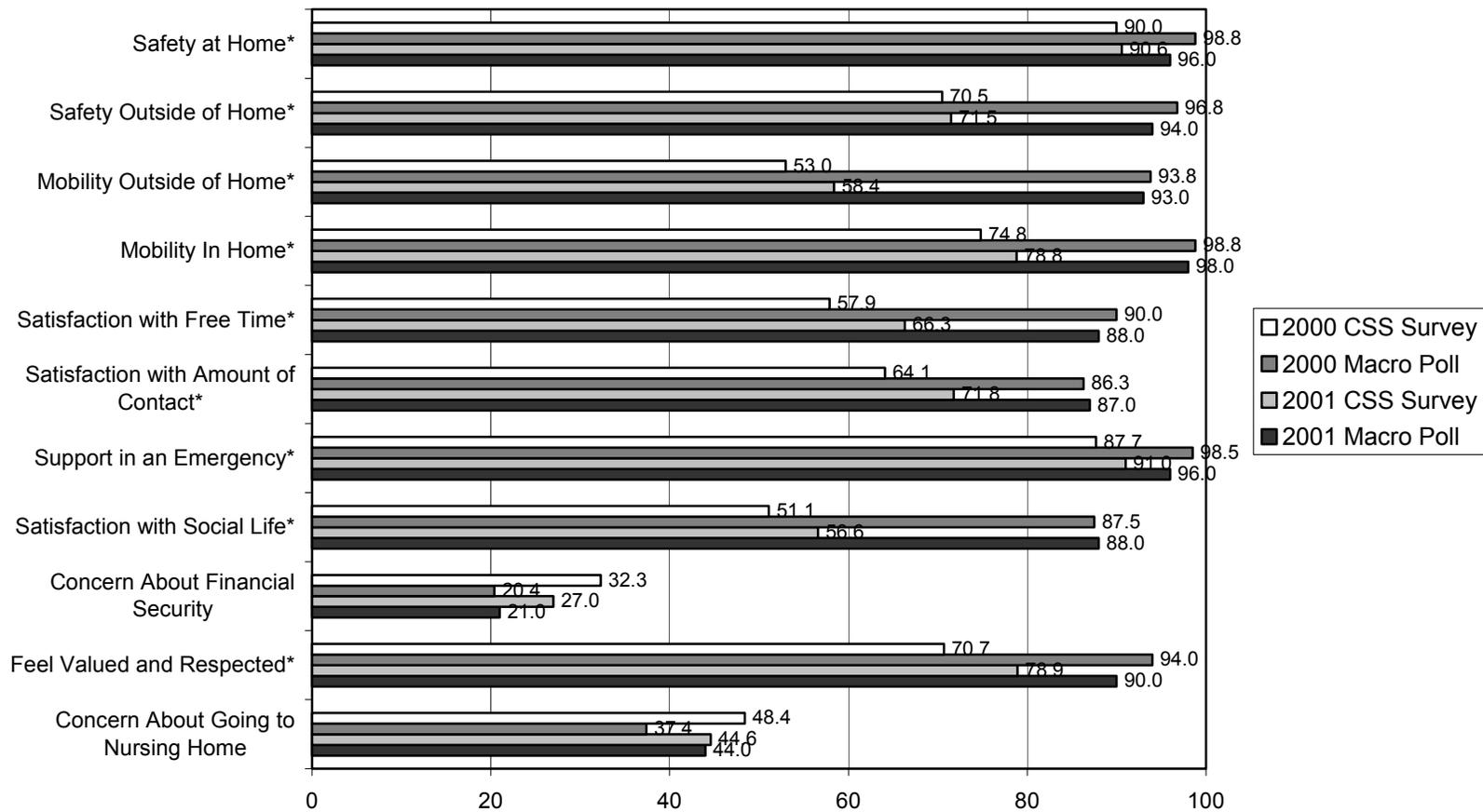
Most elderly and disabled Vermonters who receive assistance from the state's long-term care programs perceived the quality of their life as being generally good. Specifically:

- Nearly 80% (78.9%) of consumers indicated they felt valued and respected.
- The majority of consumers felt safe in their home (90.6%) and safe in their communities (71.5%).
- Most consumers (91.%) had someone they can rely on for support in an emergency.

However, long-term care consumers may experience a lesser quality of life than other Vermonters. On similar quality of life measures, the general Vermont public was consistently more positive about the quality of their lives than long-term care consumers, and indicated significantly higher levels of satisfaction in a number of areas. For example:

- Long-term care consumers were far less likely than other Vermonters to be satisfied with their social lives and connections to the community. While 88.0% of Vermonters indicated they were satisfied with their social lives, only 56.6% of long-term care consumers felt the same way.
- Members of the general Vermont public were more than 15% more likely to be satisfied with the amount of contact they have with family and friends (87% vs. 71.8%).
- Elderly and disabled Vermonters participating in long-term care programs were less likely than the general Vermont public to feel valued and respected (78.9% compared to 90.0%).

**Quality-of-Life Measures: A Comparison of Macro Poll and CSS Results
(Percentage of Respondents Indicating "Yes")**



statistical difference between 2001 Macro Poll results and 2001 Consumer Satisfaction Survey (CSS) results

**Indicates*

Consumer Satisfaction with Attendant Services Program

Long-term care consumers who participated in the State's Attendant Services Program indicated high levels of satisfaction with the care they received. For each program aspect, at least 70% of consumers were "always" or "almost always" satisfied.

- Consumers were most satisfied with the respect and courtesy shown to them by their caregivers, with over 94% indicating they were "always" or "almost always" satisfied.
- Attendant Services consumers in 2001 were more likely to indicate they were satisfied with the quality of services compared to 2000 responses (92.9% vs. 85.8%).

Consumer Satisfaction with Homemaker Program

Over 75% of long-term care consumers participating in the Homemaker Program were "always" or "almost always" satisfied with all program aspects.

- Nearly 88% of consumers indicated their caregivers "always" or "almost always" treated them with respect and courtesy.
- In 2001, significantly fewer consumers reported that they knew whom to contact with a complaint or request (76.9%) than in 2000 (88.1%).

Consumer Satisfaction with the Medicaid Waiver Program

Elderly and disabled Vermonters participating in the state's Medicaid Waiver Program on average indicated higher levels of satisfaction with this program than all other programs evaluated in the study. These high levels of satisfaction did not change significantly in 2001 compared to 2000.

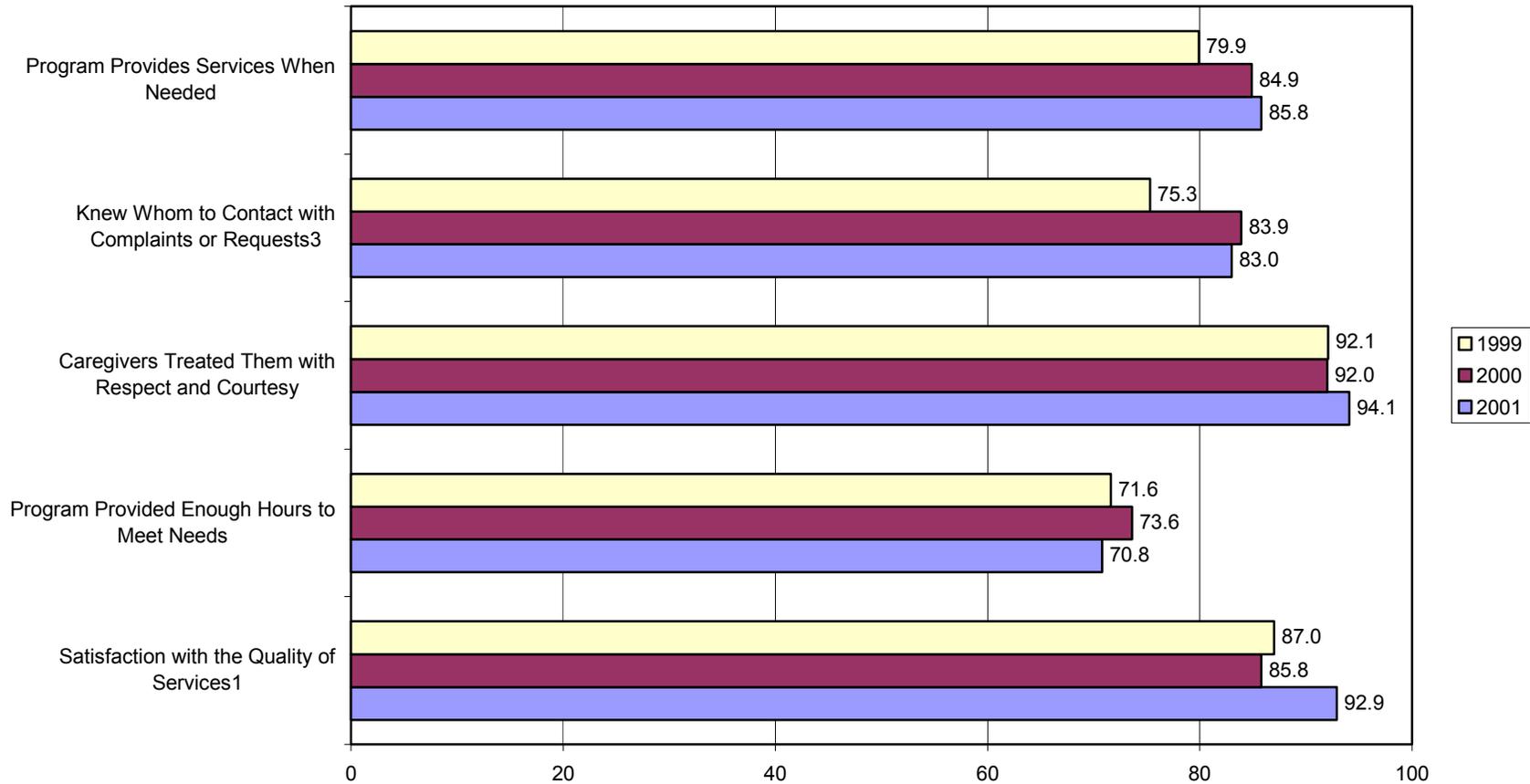
- Consumers were most satisfied with the respect and courtesy shown to them by their caregivers, with 95.2% having indicated their caregiver "always" or "almost always" treated them with respect and courtesy.
- Medicaid Waiver Program participants were least satisfied with when and where services were offered. However, even in this category, 87.9% of Medicaid Waiver Program consumers were satisfied with this program aspect.

Consumer Satisfaction with the Adult Day Center Program

Satisfaction levels with the Adult Day Center Program appear lower than satisfaction levels with other programs. However, Adult Day Center consumers were asked to rate different program aspects than consumers of the other programs included in the survey. The majority of consumers were satisfied with many aspects of the Adult Day Center Program.

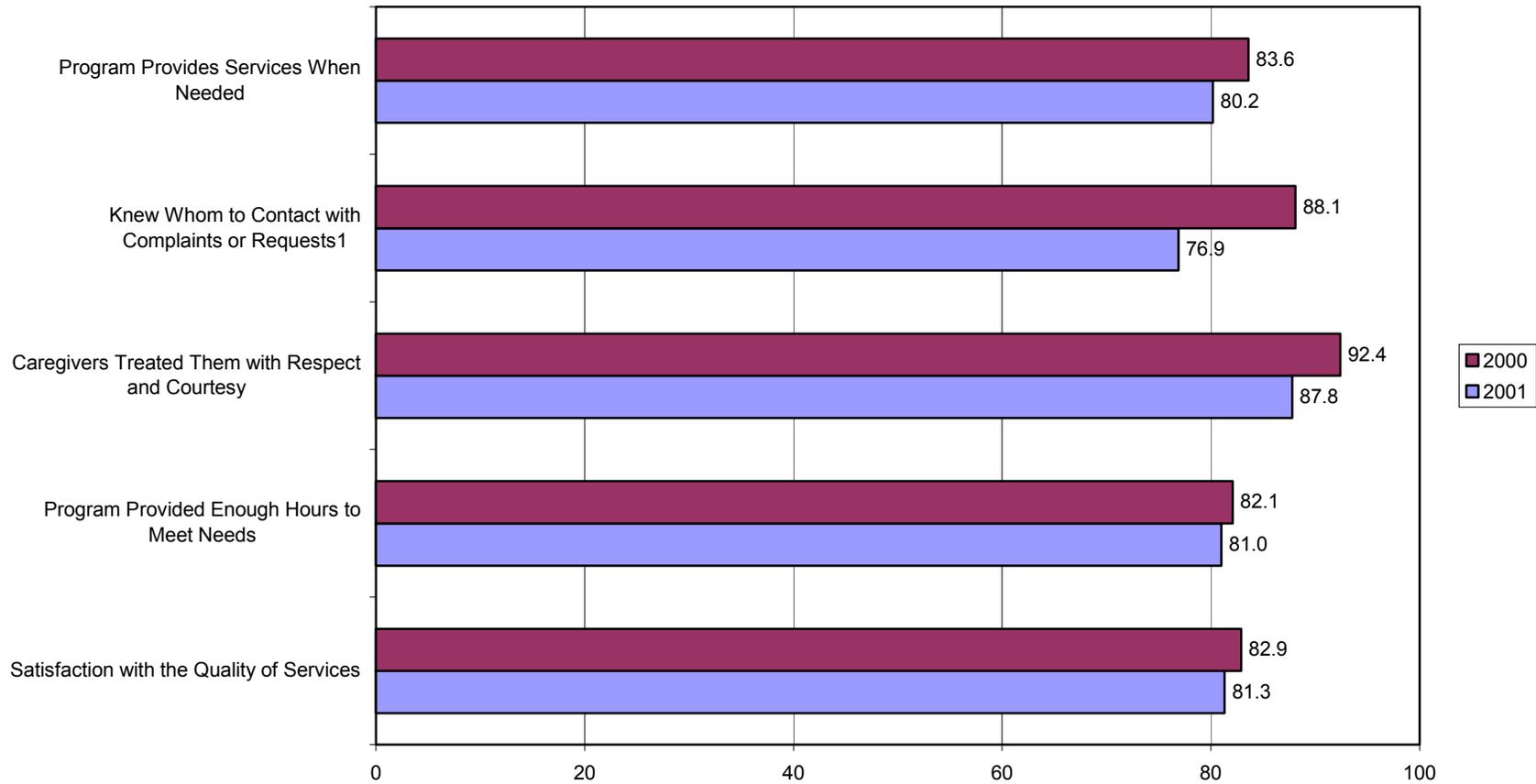
- Consumers were most satisfied with days and hours of the program operation: 86.0% were always or almost always satisfied with this aspect of the Adult Day Center program.
- In addition, 71.8% of Adult Day Center consumers felt that the activities offered by the program matched their interests.
- However, only 66.0% of consumers could regularly afford all of the hours or services required.

**Percentage of Respondents Who Were "Always" or "Almost Always" Satisfied
with Attendant Services Program Aspects**



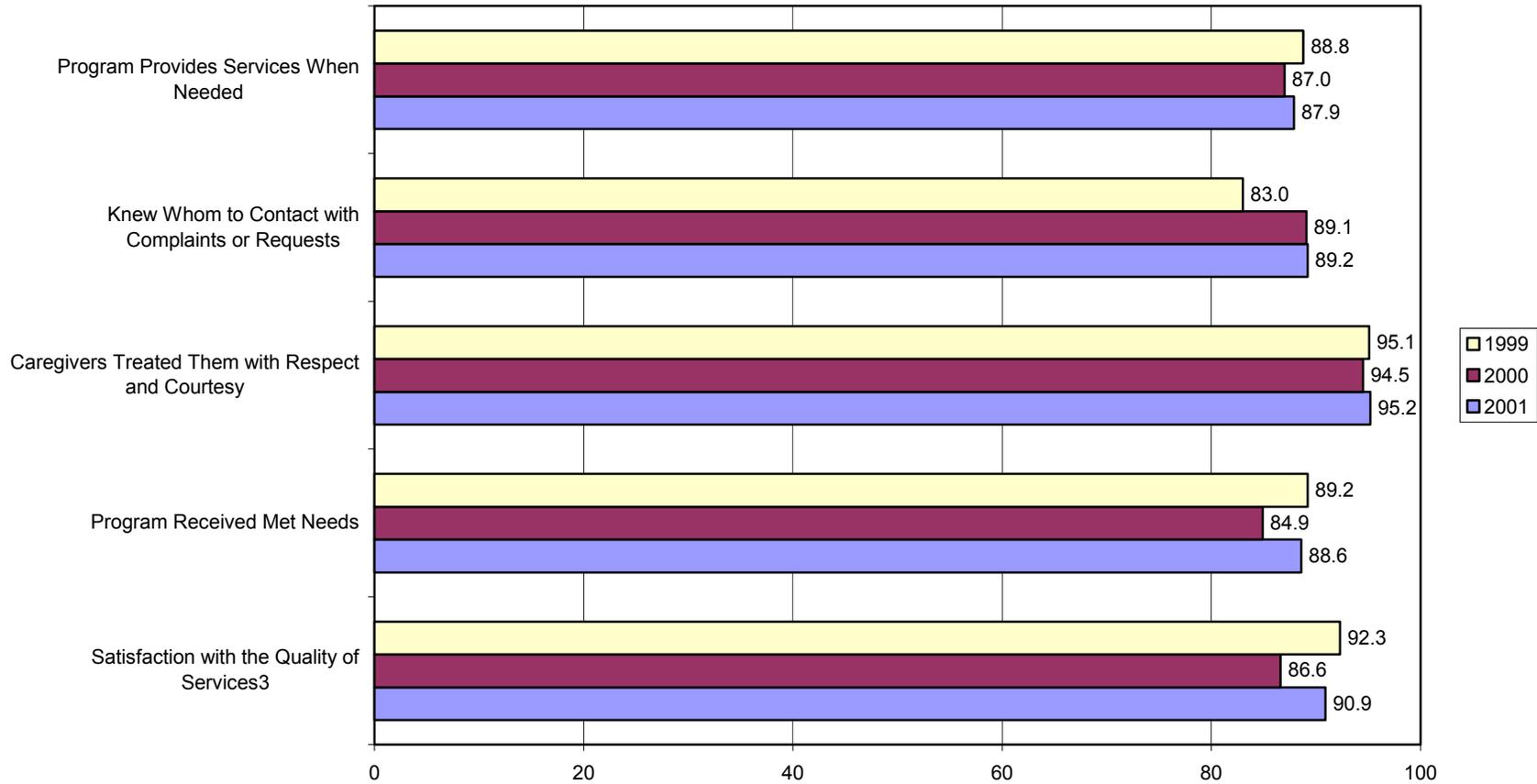
¹ Indicates statistical difference between 2000 and 2001
² Indicates statistical difference between 1999 and 2001
³ Indicates statistical difference between 1999 and 2000
⁴ Indicates statistical difference between 1999, 2000 and 2001
⁵ Indicates statistical difference between 1999 and 2001 and also 2000 and 2001
⁶ Indicates statistical difference between 1999 and 2000 and also 2000 and 2001
⁷ Indicates statistical difference between 1999 and 2000 and also 1999 and 2001

**Percentage of Respondents Who Were "Always" or "Almost Always" Satisfied
with Homemaker Program Aspects**



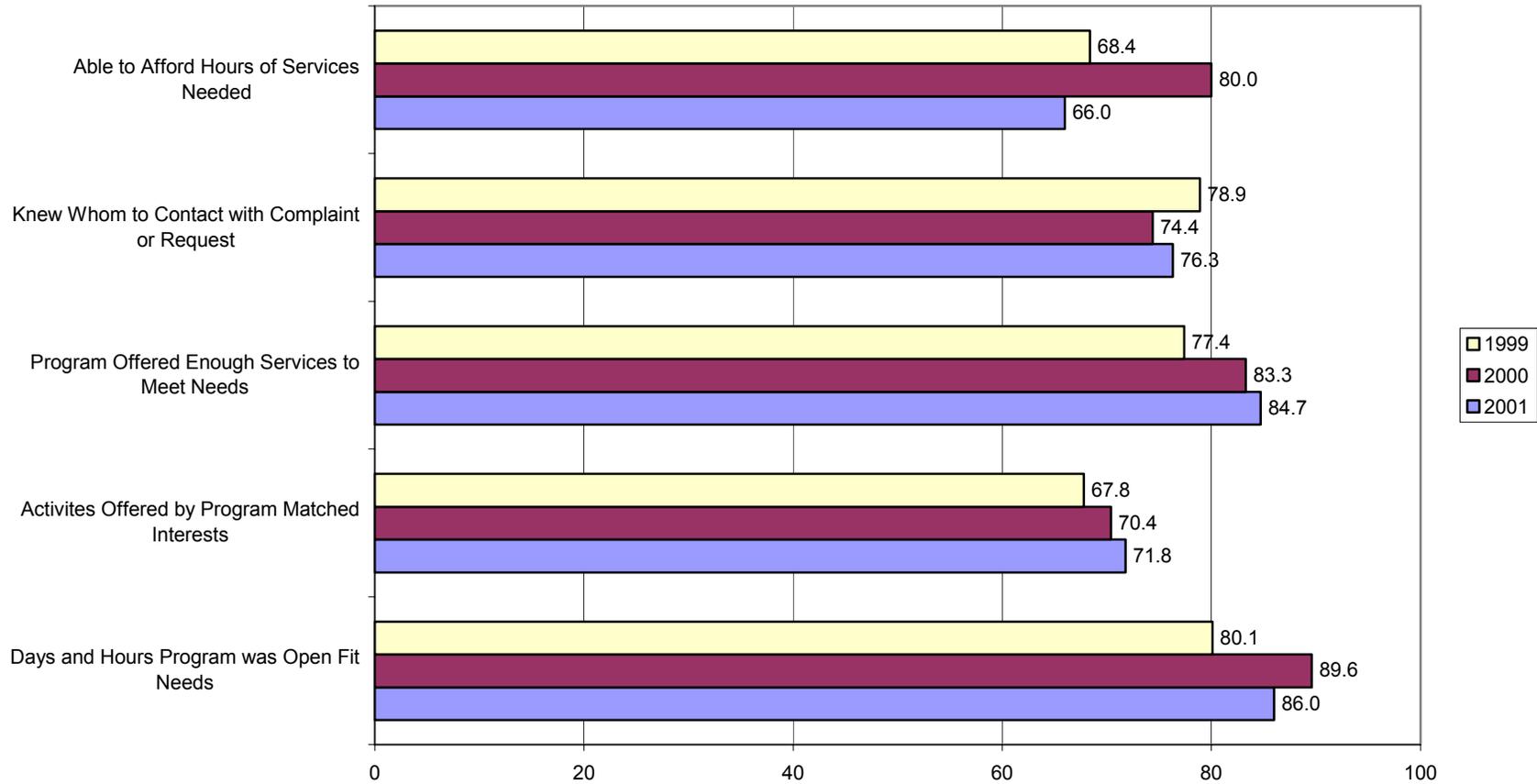
*1 Indicates statistical difference between 2000 and 2001
 2 Indicates statistical difference between 1999 and 2001
 3 Indicates statistical difference between 1999 and 2000
 4 Indicates statistical difference between 1999, 2000 and 2001
 5 Indicates statistical difference between 1999 and 2001 and also 2000 and 2001
 6 Indicates statistical difference between 1999 and 2000 and also 2000 and 2001
 7 Indicates statistical difference between 1999 and 2000 and also 1999 and 2001*

**Percentage of Respondents Who Were "Always" or "Almost Always" Satisfied
with Medicaid Waiver Program Aspects**



1 Indicates statistical difference between 2000 and 2001
 2 Indicates statistical difference between 1999 and 2001
 3 Indicates statistical difference between 1999 and 2000
 4 Indicates statistical difference between 1999, 2000 and 2001
 5 Indicates statistical difference between 1999 and 2001 and also 2000 and 2001
 6 Indicates statistical difference between 1999 and 2000 and also 2000 and 2001
 7 Indicates statistical difference between 1999 and 2000 and also 1999 and 2001

**Percentage of Respondents Who Were "Always" or "Almost Always" Satisfied
with Adult Day Center Program Aspects**



- 1 Indicates statistical difference between 2000 and 2001
- 2 Indicates statistical difference between 1999 and 2001
- 3 Indicates statistical difference between 1999 and 2000
- 4 Indicates statistical difference between 1999, 2000 and 2001
- 5 Indicates statistical difference between 1999 and 2001 and also 2000 and 2001
- 6 Indicates statistical difference between 1999 and 2000 and also 2000 and 2001
- 7 Indicates statistical difference between 1999 and 2000 and also 1999 and 2001

APPENDIX G

APPENDIX G

Vermont Agency of Human Services
Department of Aging and Disabilities
2001 Consumer Satisfaction Survey
PHONE SURVEY VERSION
February 5, 2002

{Intro 1}

Hello, this is _____ calling from Macro International on behalf of the Vermont Department of Aging and Disabilities. May I please speak with {Name}?

- 1 Yes, on the phone
- 2 Yes, coming to phone **{Repeat}**
- 3 No, not available **{Terminate}**
- 4 Respondent physically/mentally not able to participate in survey **{Go to Label Proxy}**

{Intro 2}

Section 1: Introduction

I'm calling on behalf of the Vermont Agency of Human Services, Department of Aging and Disabilities. We're doing a study of customer satisfaction of Vermonters who use our services.

The information from this survey will be used to help the State of Vermont and your community improve long-term care services. You were chosen to participate in the survey because you receive or have received help in 2001 from a long-term care program such as Adult Day Programs, Medicaid Waiver Services, Homemaker Services and Attendant Services.

You can be assured that your responses to this survey will be strictly confidential. You're answers will never be shared with your caregivers, program staff, or anyone else associated with your care or services.

As you answer the next few questions, please respond in terms of your experience with your long-term care and services in general, rather than thinking of individual services. These services include Adult Day Programs, Medicaid Waiver Services, Homemakers Services and Attendant Services.

- 1 Continue **{Go to Label Survey}**
- 2 Terminate
- 3 Respondent physically/mentally not able to participate in survey **{Go to Label Proxy}**

{Label

Proxy}

It is important that we obtain information about {Name}'s experiences with long-term care services in the state. We'd like to conduct this survey with whoever is best able to answer for {Name}. May I speak to that person?

- 1 Yes, on the phone **{Go to Label Proxy3}**
- 2 Yes, respondent coming to the phone **{Go to Label Proxy2}**
- 3 No, not available **{Terminate}**

{Label Proxy2}

Are you the person that is best able to answer for {Name}?

- 1 Yes **{Go to Proxy3}**
- 2 No **{Repeat Proxy}**

{Label Proxy3}

We're doing a study of customer satisfaction of Vermonters who use our services. The information from this survey will be used to help the State of Vermont and your community improve long-term care services. {Name} was chosen to participate in the survey because {name} receives or has received help in the past from a long-term care program such as Adult Day Programs, Medicaid Waiver Services, Homemakers Services and Attendant Services.

All responses to this survey will be strictly confidential. {name}'s answers will never be shared with program staff, care givers, or anyone else associated with {name}'s care or services.

As you answer the next few questions, please respond in terms of {name}'s experience with long-term care and services in general, rather than thinking of individual services. These services include Adult Day Programs, Medicaid Waiver Services, Homemakers Services and Attendant Services.

{Label Survey}

Section 2: General Satisfaction with Services

Question 3:

For the next series of questions, please think about *all* of the services you receive and programs in which you participate. For example, if you participate in more than one program, think about your experiences with the services you receive from *all* of the programs as a group.

I am going to read some statements that describe various aspects of long-term care programs. Please give each statement a letter grade using a letter grade scale where A means Excellent, B means Good, C means Average, D means Poor, F means Unsatisfactory.

3.A The **amount of choice and control** you had when you planned the services or care you would receive. Would you say....

3.A.1 A= Excellent

3.A.2 B= Good

3.A.3 C= Average

3.A.4 D= Poor

3.A.5 F= Unsatisfactory

3.A.6 Does not apply to respondent [Do Not Read]

3.A.8 Don't know [Do Not Read]

3.A.9 Refused [Do Not Read]

3.B The overall **quality** of the help you receive. Would you say...

3.B.1 A= Excellent

3.B.2 B= Good

3.B.3 C= Average

3.B.4 D= Poor

3.B.5 F= Unsatisfactory

3.B.6 Does not apply to respondent [Do Not Read]

3.B.8 Don't know [Do Not Read]

3.B.9 Refused [Do Not Read]

3.C The **timeliness** of your services. *For example, did your services start when you needed them?* Would you say...

3.C.1 A= Excellent

3.C.2 B= Good

3.C.3 C= Average

3.C.4 D= Poor

3.C.5 F= Unsatisfactory

3.C.6 Does not apply to respondent [Do Not Read]

3.C.8 Don't know [Do Not Read]

3.C.9 Refused [Do Not Read]

3.D **When** you receive your services or care? *For example, do they fit with your schedule?*
Would you say...

3.D.1 A= Excellent

3.D.2 B= Good

3.D.3 C= Average

3.D.4 D= Poor

3.D.5 F= Unsatisfactory

3.D.6 Does not apply to respondent [Do Not Read]

3.D.8 Don't know [Do Not Read]

3.D.9 Refused [Do Not Read]

3.E The **communication** between you and the people who help you?

3.E.1 A= Excellent

3.E.2 B= Good

3.E.3 C= Average

3.E.4 D= Poor

3.E.5 F= Unsatisfactory

3.E.6 Does not apply to respondent [Do Not Read]

3.E.8 Don't know [Do Not Read]

3.E.9 Refused [Do Not Read]

3.F The **reliability** of the people who help you. *For example, do they show up when they are supposed to be there?* Would you say?

3.F.1 A= Excellent

3.F.2 B= Good

3.F.3 C= Average

3.F.4 D= Poor

3.F.5 F= Unsatisfactory

3.F.6 Does not apply to respondent [Do Not Read]

3.F.8 Don't know [Do Not Read]

3.F.9 Refused [Do Not Read]

3.G The degree to which the services **meet your needs?** Would you say...

3.G.1 A= Excellent

3.G.2 B= Good

3.G.3 C= Average

3.G.4 D= Poor

- 3.G.5 F= Unsatisfactory
- 3.G.6 Does not apply to respondent [Do Not Read]
- 3.G.8 Don't know [Do Not Read]
- 3.G.9 Refused [Do Not Read]

3.H How well **problems or concerns** you have with your care are taken care of?

- 3.H.1 A= Excellent
- 3.H.2 B= Good
- 3.H.3 C= Average
- 3.H.4 D= Poor
- 3.H.5 F= Unsatisfactory
- 3.H.6 Does not apply to respondent [Do Not Read]
- 3.H.8 Don't know [Do Not Read]
- 3.H.9 Refused [Do Not Read]

3.I The **courtesy** of those who help you? Would you say...

- 3.I.1 A= Excellent
- 3.I.2 B= Good
- 3.I.3 C= Average
- 3.I.4 D= Poor
- 3.I.5 F= Unsatisfactory
- 3.I.6 Does not apply to respondent [Do Not Read]
- 3.I.8 Don't know [Do Not Read]
- 3.I.9 Refused [Do Not Read]

3.J How well did people **listen** to your needs and preferences? Would you say...

- 3.J.1 A= Excellent
- 3.J.2 B= Good
- 3.J.3 C= Average
- 3.J.4 D= Poor
- 3.J.5 F= Unsatisfactory
- 3.J.6 Does not apply to respondent [Do Not Read]
- 3.J.8 Don't know [Do Not Read]
- 3.J.9 Refused [Do Not Read]

4 For what you pay for the services you receive, do you find them to be of good value?

[If necessary: These services include Adult Day Programs, Medicaid Waiver Services, Homemakers Services and Attendant Services.]

- 4.1 Yes
- 4.2 No
- 4.6 Does not apply to respondent [Do Not Read]
- 4.8 Don't know [Do Not Read]
- 4.9 Refused [Do Not Read]

5 Would you say the help you have received has made your life...

- 5.1 Much better
- 5.2 Somewhat better
- 5.2 About the same
- 5.3 Somewhat worse
- 5.4 Much worse
- 5.6 Does not apply to respondent [Do Not Read]
- 5.8 Don't know [Do Not Read]
- 5.9 Refused [Do Not Read]

6 How easy would it be for you to stay in your home if you didn't receive services?
Would you say...

- 6.1 Very easy
- 6.2 Easy
- 6.3 About the same
- 6.4 Difficult
- 6.5 Very difficult
- 6.6 Does not apply to respondent [Do Not Read]
- 6.8 Don't know [Do Not Read]
- 6.9 Refused [Do Not Read]

Section 3: Quality of Life

7 The following questions refer to how you feel about your life now. Please indicate how well the statements describe your life with either yes, somewhat, or no.

7.A I feel safe in the home where I live. Would you say...

7.A.1 Yes

7.A.2 Somewhat

7.A.3 No

7.A.8 Don't know [Do Not Read]

7.A.9 Refused [Do Not Read]

7.B I feel safe out in my community. Would you say...

7.B.1 Yes

7.B.2 Somewhat

7.B.3 No

7.B.8 Don't know [Do Not Read]

7.B.9 Refused [Do Not Read]

7.C I can get where I need or want to go. Would you say...

7.C.1 Yes

7.C.2 Somewhat

7.C.3 No

7.C.8 Don't know [Do Not Read]

7.C.9 Refused [Do Not Read]

7.D I can get around inside my home as much as I need to. Would you say...

7.D.1 Yes

7.D.2 Somewhat

7.D.3 No

7.D.8 Don't know [Do Not Read]

7.D.9 Refused [Do Not Read]

7.E I am satisfied with how I spend my free time. Would you say...

7.E.1 Yes

7.E.2 Somewhat

7.E.3 No

7.E.8 Don't know [Do Not Read]

7.E.9 Refused [Do Not Read]

7.F I am satisfied with the amount of contact I have with my family and friends. Would you say...

7.F.1 Yes

7.F.2 Somewhat

7.F.3 No

7.F.8 Don't know [Do Not Read]

7.F.9 Refused [Do Not Read]

7.G I have someone I can count on in an emergency. Would you say...

7.G.1 Yes

7.G.2 Somewhat

7.G.3 No

7.G.8 Don't know [Do Not Read]

7.G.9 Refused [Do Not Read]

7.H I feel satisfied with my social life and with my connection to my community. Would you say...

7.H.1 Yes

7.H.2 Somewhat

7.H.3 No

7.H.8 Don't know [Do Not Read]

7.H.9 Refused [Do Not Read]

7.I I am concerned that I don't have enough money for the essentials. Would you say...

7.I.1 Yes

7.I.2 Somewhat

7.I.3 No

7.I.8 Don't know [Do Not Read]

7.I.9 Refused [Do Not Read]

7.J I feel valued and respected. Would you say...

7.J.1 Yes

7.J.2 Somewhat

7.J.3 No

7.J.8 Don't know [Do Not Read]

7.J.9 Refused [Do Not Read]

7.K I am concerned that some day I may have to go to a nursing home. Would you say...

7.K.1 Yes

7.K.2 Somewhat

7.K.3 No

7.K.8 Don't know [Do Not Read]

7.K.9 Refused [Do Not Read]

8. Overall, how would you rate your quality of life?

8.1. A= Excellent

8.2 B= Good

8.3 C= Average

8.4 D= Poor

8.5 F= Unsatisfactory

8.6 Does not apply to respondent [Do Not Read]

8.8 Don't know [Do Not Read]

8.9 Refused [Do Not Read]

Satisfaction with long-term care programs

For the next few questions, I would like you to think about the services you receive from each one of the state-sponsored programs in which you participate.

Section 4: Attendant Services Program

{Ask this section only for participants of the Attendant Services program, as indicated in the sample file.}

9 The following series of questions are about your experiences with the Attendant Services Program. [The Attendant Services Program provides assistance with personal care for adults with disabilities. Participants hire, train, and supervise their attendants.](#)

**Please rate your opinion about each of the statements using the following scale.
Always, Almost Always, Sometimes, Seldom, or Never.**

9.A I am satisfied with the quality of the services I receive from the Attendant Services Program. Would you say...

9.A.1 Always

9.A.2 Almost always

9.A.3 Sometimes

9.A.4 Seldom

9.A.5 Never

9.A.8 Don't know [Do Not Read]

9.A.9 Refused [Do Not Read]

9.B The Attendant Services Program provides enough hours to meet my needs. Would you say...

9.B.1 Always

9.B.2 Almost always

9.B.3 Sometimes

9.B.4 Seldom

9.B.5 Never

9.B.8 Don't know [Do Not Read]

9.B.9 Refused [Do Not Read]

9.C My care giver(s) in the Attendant Services Program treat(s) me with respect and courtesy.
Would you say...

9.C.1 Always

9.C.2 Almost always

9.C.3 Sometimes

9.C.4 Seldom

9.C.5 Never

9.C.8 Don't know [Do Not Read]

9.C.9 Refused [Do Not Read]

9.D I know whom to contact if I have a complaint about the Attendant Services Program or if
I need more help from the Attendant Services Program Would you say...

9.D.1 Always

9.D.2 Almost always

9.D.3 Sometimes

9.D.4 Seldom

9.D.5 Never

9.D.8 Don't know [Do Not Read]

9.D.9 Refused [Do Not Read]

9.E The Attendant Services Program provides services to me when and where I need them.
Would you say...

9.E.1 Always

9.E.2 Almost always

9.E.3 Sometimes

9.E.4 Seldom

9.E.5 Never

9.E.8 Don't know [Do Not Read]

9.E.9 Refused [Do Not Read]

{Label HDM}

Section 5: Homemakers Program

{Ask this section only for participants of the Homemakers program, as indicated in the sample file.}

10 The following series of questions are about your experiences with Homemakers Program. [The Homemaker program serves adult Vermonters who need help at home with activities such as cleaning, laundry, shopping, respite care, and limited person care.](#)

Please rate your opinion about each of the statements using the following scale. Always, Almost Always, Sometimes, Seldom, or Never.

10.A I am satisfied with the quality of services I receive from the Homemaker program. Would you say...

10.A.1 Always

10.A.2 Almost always

10.A.3 Sometimes

10.A.4 Seldom

10.A.5 Never

10.A.8 Don't know [Do Not Read]

10.A.9 Refused [Do Not Read]

10.B The services I receive from the Homemaker program meet my needs. Would you say...

10.B.1 Always

10.B.2 Almost always

10.B.3 Sometimes

10.B.4 Seldom

10.B.5 Never

10.B.8 Don't know [Do Not Read]

10.B.9 Refused [Do Not Read]

10.C My caregivers in the Homemaker program treat me with respect and courtesy. Would you say...

10.C.1 Always

10.C.2 Almost always

10.C.3 Sometimes

10.C.4 Seldom

10.C.5 Never

10.C.8 Don't know [Do Not Read]

10.C.9 Refused [Do Not Read]

10.D I know who to contact if I have a complaint about the Homemaker program or if I need more help from the Homemaker program. Would you say...

10.D.1 Always

10.D.2 Almost always

10.D.3 Sometimes

10.D.4 Seldom

10.D.5 Never

10.D.8 Don't know

[Do Not Read]

10.D.9 Refused

[Do Not Read]

10.E The Homemaker Program provides services to me when and where I need them. Would you say...

10.E.1 Always

10.E.1 Almost always

10.E.3 Sometimes

10.E.4 Seldom

10.E.5 Never

10.E.8 Don't know

[Do Not Read]

10.E.9 Refused

[Do Not Read]

{Label MWP}

Section 6: Medicaid Waiver Program

{Ask this section only for participants of the Medicaid Waiver program, as indicated in the sample file.}

11. The following series of questions are about your experiences with the Medicaid Waiver Program. [The Medicaid Waiver Program provides long-term care to elders and adults with physical disabilities who live at home. Services include help with personal care, adult day services, respite care, assistive devices and case management.](#)

Please rate your opinion about each of the statements using the following scale.
Always, Almost Always, Sometimes, Seldom, or Never.

- 11.A I am satisfied with the quality of the services I receive from the Medicaid Waiver Program. Would you say...

11.A.1 Always

11.A.2 Almost always

11.A.3 Sometimes

11.A.4 Seldom

11.A.5 Never

11.A.8 Don't know

[Do Not Read]

11.A.9 Refused

[Do Not Read]

- 11.B The services I receive from the Medicaid Waiver Program meet my needs. Would you say...

11.B.1 Always

11.B.2 Almost always

11.B.3 Sometimes

11.B.4 Seldom

11.B.5 Never

11.B.8 Don't know

[Do Not Read]

11.B.9 Refused

[Do Not Read]

- 11.C My care giver(s) in the Medicaid Waiver Program treat(s) me with respect and courtesy. Would you say...

11.C.1 Always

11.C.2 Almost always

11.C.3 Sometimes

11.C.4 Seldom

11.C.5 Never

11.C.8 Don't know [Do Not Read]
11.C.9 Refused [Do Not Read]

11.D I know whom to contact if I have a complaint about the Medicaid Waiver Program or if I need more help from the Medicaid Waiver Program. Would you say...

11.D.1 Always
11.D.2 Almost always
11.D.3 Sometimes
11.D.4 Seldom
11.D.5 Never
11.D.8 Don't know [Do Not Read]
11.D.9 Refused [Do Not Read]

11.E The Medicaid Waiver Program provides services to me when and where I need them. Would you say...

11.E.1 Always
11.E.2 Almost always
11.E.3 Sometimes
11.E.4 Seldom
11.E.5 Never
11.E.8 Don't know [Do Not Read]
11.E.9 Refused [Do Not Read]

Section 7: Adult Day Services Program

{Ask this section only for participants of the Adult Day Services program, as indicated in the sample file.}

- 12 The following series of questions are about your experiences with the Adult Day Center Program. [Adult Day Centers provide day programs for adults with cognitive or physical disabilities including activities, social interaction, meals and personal and health screening.](#)

Please rate your opinion about each of the statements using the following scale. Always, Almost Always, Sometimes, Seldom, or Never.

- 12.A The days and hours that the Adult Day Center is open fit my needs. Would you say...

12.A.1 Always

12.A.2 Almost always

12.A.3 Sometimes

12.A.4 Seldom

12.A.5 Never

12.A.8 Don't know

[Do Not Read]

12.A.9 Refused

[Do Not Read]

- 12.B The activities offered at my Adult Day Center match my interests. Would you say...

12.B.1 Always

12.B.2 Almost always

12.B.3 Sometimes

12.B.4 Seldom

12.B.5 Never

12.B.8 Don't know

[Do Not Read]

12.B.9 Refused

[Do Not Read]

- 12.C The Adult Day Center offers enough services to suit my needs. For example, nursing, physical therapy, personal care and meals. Would you say...

12.C.1 Always

12.C.2 Almost always

12.C.3 Sometimes

12.C.4 Seldom

12.C.5 Never

12.C.8 Don't know

[Do Not Read]

12.C.9 Refused

[Do Not Read]

12.D I know whom to contact if I have a complaint about the Adult Day Center or if I need more help from the Adult Day Center program. Would you say...

12.D.1 Always

12.D.2 Almost always

12.D.3 Sometimes

12.D.4 Seldom

12.D.5 Never

12.D.8 Don't know

[Do Not Read]

12.D.9 Refused

[Do Not Read]

12.E I am able to afford all the hours of Adult Day Center Services that my family and I need. Would you say...

12.E.1 Always

12.E.2 Almost always

12.E.3 Sometimes

12.E.4 Seldom

12.E.5 Never

12.E.8 Don't know

[Do Not Read]

12.E.9 Refused

[Do Not Read]

Section 9: Contact Respondent

13. Would you like someone to contact you about worries or concerns you have about the services or care you are receiving from any of the State-sponsored programs that have been discussed in this survey? If so, please confirm your name and phone number. [Do Not Read Responses]

13.1 Yes - interested in being contacted

13.2 No **{Skip to Label IDEA}**

13.8 Don't know **{Skip to Label IDEA}**

13.9 Refused **{Skip to Label IDEA}**

13.A Please tell me your name and phone number so that we can have someone contact you.

Name **{Specify:_____}**

13.B Phone **{Specify: (802)____-____}** **{Range: number of digits entered =7}**

13.C Please give a brief description of the worry or concern you would like to be contacted about?

{Record response verbatim}

{Label IDEA}

Section 10: Improvements

14 The Department of Aging and Disabilities is very interested in hearing your ideas about how to make things work better for you and other Vermonters. Please tell us how you think your services or care could be improved.

14.1
[Record response verbatim]

14.2 No Comment
14.8 Don't know
14.9 Refused

Section 11: Comments

15 Do you have any comments you would like to make about the help you receive?

15.1 Yes
[Record response verbatim]

15.2 No
15.8 Don't Know [Do Not Read]
15.9 Refused [Do Not Read]

Section 12: Demographics

[DO NOT READ]

- 1 [Interviewer: Who was this interview conducted with?]
- 1.1 Respondent- the person who receives the services or care
- 1.2 Other/Proxy - proxy for the respondent

[DO NOT READ/VOICE RECOGNITION ONLY]

- 2 Are you male or female? [ONLY IF NECESSARY]
[Interviewer prompt: if respondent is proxy, record the gender of the person who actually receives the services.]
- 2.1 Male
- 2.2 Female
- 2.8 Don't know
- 2.9 Refused

17 That was my last question. Thank you for taking time to participate in this very important study.

APPENDIX H

Shaping the Future of Long Term Care

2000 - 2010

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May 2003**

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EXECUTIVE SUMMARY

The next 20 years offer an opportunity to create an ideal long term care system for elders and adults with physical disabilities. With that in mind, the Vermont Department of Aging and Disabilities undertook a project to determine the components of a successful system to address future long term care needs. Looking forward in time allows the Department to engage in thoughtful planning and sound system development.

Vermont's fastest growing age group is its eldest—those 85 years old and older. Although the total population is projected to grow by 8% this decade, the number of Vermont's eldest will increase by a dramatic 27%. While a comparatively small group, these elders have the greatest need for long term care services. However, despite media coverage to the contrary, demand for these services will not peak until after 2030, when the oldest baby boomers turn 85.

The prevalence of disability for the younger population is projected to climb this decade. However, the disability rate among people 65 years old and older is dropping. Utilization of nursing homes has declined as well. The decrease in the use of nursing homes has occurred for all age groups and is projected to continue into the future.

Vermont's 1996 pioneering long term care legislation, Act 160, allows the Department of Aging and Disabilities to shift dollars from institutional settings to home-based services. As a result, Vermont has been able to serve more people for significantly less money. The anticipated delay in baby boomer demand, coupled with the projected declines in both elder disability and nursing home use, portend an *extended* movement away from institutional care toward community-based services.

Vermont has been unable to adequately address its need for community-based services; demand outstrips capacity. By the end of this decade, the number of people needing assistance will climb by 52%. Programs such as home health, case management and adult day are stretched thin. Funds for public transportation, home modification and prevention services continue to be insufficient. The two greatest challenges are finding more caregivers to provide needed care, and developing more accessible and affordable housing.

The present distribution of long term care resources prevents Vermont from addressing these gaps. For the last 5 years, the State has had excess institutional capacity with approximately 300 empty nursing home beds at any

given time. Vermont needs to strike a better balance between the number of nursing home beds and the number of people served in community settings. A first step toward achieving this balance is to establish a county minimum of 40 Home and Community-Based Medicaid Waiver slots for every 60 Medicaid funded nursing home beds. If this ratio existed across the State today, an additional 277 people in the community would be served on the Home and Community-Based Medicaid Waiver program (with a corresponding decrease in nursing home use) for a savings of \$8.5 million in Medicaid expenditures.

Planning for the future affords a unique opportunity to properly serve the needs of Vermonters. This report sets targets to achieve a more ideal long term care system.

Recommendations:

The following recommendations, if implemented, will result in a balanced and sustainable system of care for elders and adults with physical disabilities. Actual implementation in any given year will depend on the State's fiscal situation and assumes that Federal/State Medicaid programs remain relatively unchanged. It is important to note that if the goal to achieve a 40/60 balance were realized, there would be sufficient savings to fund the needed Medicaid Waiver slots and many of these recommendations. However, additional sources of money are needed in order to raise caregiver wages, fund new infrastructure for adult day programs, and develop new housing options.

1. In accordance with consumer preference, continue to decrease reliance on nursing home care. Develop alternatives so that at least 40% of the people needing Medicaid funded nursing home level of care receive that care at home or in other community settings. Update this target annually based on utilization and projected need.
2. Increase Home and Community-Based Medicaid Waiver slots by 100 each year and continue to allocate them to people in greatest need.
3. Increase the Attendant Service Program to serve an additional 100 people by 2010. (See Appendix, Table 4.)
4. As funds permit, continue to improve wages and benefits for personal caregivers in all settings until caregivers receive a *starting wage* of at least \$10/hour, along with basic benefits such as health insurance, sick time and vacation leave. Wages in all settings should be increased annually by an inflation factor.

5. Develop additional supportive housing such as Enhanced Residential Care, Assisted Living, group-directed congregate housing, and adult family care. Increase funding for home modification. Continue to promote universal design in all new housing construction.
6. Increase the capacity of adult day centers to serve 1,500 people in 2010, up from 800 in the year 2000. This reflects an increase in daily capacity from 441 to 720. (See Appendix, Table 4.)
7. Expand the capacity of the Area Agencies on Aging to provide case management to more elders. Develop a program to provide case management assistance to adults with physical disabilities between the ages of 18 and 60 who do not qualify for such assistance from any other program.
8. Expand community-based prevention and health promotion programs for elders and adults with physical disabilities.
9. Expand the Homemaker Program to serve 1,300 people by the year 2010. In 2000, this program served 700 people. (See Appendix, Table 4.)
10. Expand and improve the dissemination of public information so that all elders and adults with physical disabilities know how to access the services they need through web sites, publications, the media, and information and assistance lines.

INTRODUCTION

Vermont has an aging population and a growing number of adults with physical disabilities. If the Department of Aging and Disabilities is to meet the demand for services in the future, it must have a clear idea of what is needed along with a workable plan.

This report projects the need for long term care services in 2005 and 2010 and makes recommendations for addressing that need. The Department's work plan is based on the most comprehensive data of any Vermont report on elders or adults with physical disabilities to date. Using a model developed by The Lewin Group that incorporates demographics from the 2000 Census and the Department's databases, we now have projections of the use of specific programs and services. (See Appendix, Tables 4 & 5.) This report is intended to be a living document, adjusted annually to reflect changing demographics and trends. As a result, the Department will always be planning ten years ahead.

For over 30 years, the State of Vermont has had a policy of serving elders and adults with disabilities with dignity and independence in the setting of their choice. During the last quarter century, there have been a number of studies and reports with numerous recommendations. Many of these recommendations have been implemented; others remain to be realized.

In 1976, the Office on Aging authored a report, "In the Wrong Place." Its major theme was that many people were placed in nursing homes unnecessarily when they would have preferred to be at home. The report listed a number of steps that could be taken to address that concern. Some of the obstacles noted in the report, such as a lack of affordable and accessible housing, persist today.

In 1989, then Lieutenant Governor Howard Dean, M.D. sponsored a Commission on Long Term Care and issued a report calling for, among other things, a department of long term care. That became a reality with the creation of the Department of Aging and Disabilities.

In 1991, the Department of Aging and Disabilities produced a report entitled "Long Term Care in Vermont." Again, this study examined the balance between institutional services and home-based care, emphasizing the importance of serving people in the least restrictive environment. The report made a recommendation which at the time was groundbreaking: spend no more than 70% of all public long term care funds on institutional services and no less than 30% on home-based alternatives. Twelve years later, this ratio has been achieved.

In 1995, the Health Resource Management Plan for the period 1996-1999 first outlined how the State might “shift the balance” between institutional care and home-based care. The Plan recommended a moratorium on the construction of new nursing home beds and laid the foundation for the passage of the landmark legislation known as **Act 160**. This Act required the Agency of Human Services to earmark “saved” dollars (resulting from reduced nursing home utilization) from the Medicaid nursing home appropriation. These funds were then invested in home and community-based alternatives.

The implementation of Act 160 resulted in dramatic changes for Vermont’s long term care system. Nursing home occupancy dropped to 90%, from a high of 97%. The major alternative to nursing home care, the Home and Community-Based Medicaid Waiver program, served 400 people in 1996. Today it serves nearly 1,200 individuals. Hundreds of Vermonters who had no choice but to enter a nursing home just a few years ago now have a variety of options.

This shift of public resources has produced significant savings for the State budget. As directed by Act 160, these savings have been reinvested to increase adult day services, improve residential care homes, raise wages for caregivers, enhance case management, pay for home modification, and fund a variety of other improvements to the community-based system. Despite the shift, Medicaid nursing home daily rates have risen significantly and the quality of care in Vermont nursing homes continues to be among the highest in the country.

It is our hope that this report will generate significant and meaningful discussion among policy makers, providers and citizens. Only when everyone is informed and fully engaged in the planning will we have the system of care and services Vermonters want.

- **Patrick Flood, Commissioner**

Methodology

The Department of Aging and Disabilities contracted with The Lewin Group to project both the need for long term care services and the capacity of Vermont's system to meet that need. The target populations are elders and adults with physical disabilities. Vermont-specific data on population growth, demographics, and program utilization were incorporated into Lewin's model to derive both "need" and "use" projections for 2005 and 2010.

Vermont population data from the U.S. Census 2000 served as the baseline. The University of Massachusetts Institute for Social and Economic Research (MISER) developed population projections for the periods 2005 and 2010. The Lewin Group integrated the population projections with a variety of data sources, including disability data, population characteristics, income and program participation, nursing home utilization, and the Department's Fiscal Year 2000 actual program use, to produce a set of tables that describe Vermont's need and use of long term care services by county.¹ (See Appendix.) Detailed methodology reports from both MISER and The Lewin Group are available from the Department.

Two essential assumptions drive the results of this model: the disability rate trend and the nursing facility use rate trend. The first is a major determinate of long term care need, and the second influences the level of services required in the community. These assumptions can be adjusted over time as demographics and trends change. (See Appendix, Assumptions Sheet.)

The disability rate trend for individuals younger than 65 years old utilizes growth assumptions from the Social Security Administration to determine the increase in the percentage of workers receiving Disability Insurance benefits. This trend was applied to children as well because Lewin lacked superior data on which to base childhood trends. For people age 65 and older, the disability trend was derived from Manton's recent analysis of the 1999 National Long Term Care

¹ Lewin relied principally on the following sources of data, all from the U.S. Bureau of the Census: (1) for detailed data on Activities of Daily Living (ADLs), the 1996 Survey of Income and Program Participation; (2) for county-level general disability data, the 1990 Public Use Microdata Sample (PUMS); and (3) for the most recent state-level general disability data, Current Population Survey (CPS) data from 1999 to 2001. Note that as of this report's publication, the U.S. Census had not released the 2000 PUMS, which would have provided richer disability data for 2000. The U.S. Census did release general disability data by county from the 2000 Census after this model was developed. However, the disability questions on the 2000 Census questionnaire are not directly comparable to those on the 1990 Census, making it difficult to build these data into the model. Lewin therefore relied on the 1999-2001 CPS data, rather than the 2000 Census, to update the estimates to 2000. The Department plans to update the model once the 2000 PUMS data are available.

Survey.² This analysis showed a 1% decline per year (between 1989 and 1999) in the age-adjusted rate of disability. Lewin assumed a slightly smaller and flattening decline for the projections, because there is debate as to whether these declines will continue into the future.

The nursing facility use rate trend assumptions are based on an analysis of Vermont's actual nursing home use during the period 1992-2002. These data include all payers, both public and private, and incorporate observed trends in nursing home use through the second quarter of 2002. The trends show the annual percent change in the per capita nursing facility use rate by age group. The trend assumptions used for the projections assume a gradual slowing of the decline in use through 2010. Changes in the nursing facility use rate largely drive the model's projections of long term care need in the community.

"Long term care need" is defined as requiring assistance with two or more activities of daily living (such as dressing, bathing, movement, toileting, eating). This measure approximates the Department's definition of "nursing home level of care", which is in keeping with eligibility criteria for many of the community-based programs. The "low-income" delineation refers to people below 175% of the Federal Poverty Level, capturing the majority of Vermont's publicly funded long term care clients served by the Department. The model excludes individuals with mental retardation and developmental disabilities. The numbers in this model are "point in time" as opposed to a yearly total. All "user" data encompass the State's fiscal year.

The tables in the Appendix display the results of the model. Tables 0 and 1 compare the number of people having "long term care need" with the number of unduplicated people who use services. The projections of use for 2005 and 2010 assume that use of home and community based services increases only enough to accommodate the shift from nursing facilities. Statewide projected use for 2005 and 2010 is based on the State's actual use in 2000³, projected forward. However, the county-level use projections for 2005 and 2010 are based on each county's share of the State's 18+ disabled population.

Tables 2 and 3 show the number of Vermonters with long term care needs, employing more detailed population characteristics.

² Manton, Kenneth F, and Gu, XiLiang, Changes in the Prevalence of Chronic Disability in the United States Black and Nonblack Population above Age 65 from 1982 to 1999. *Proceedings of the National Academy of Sciences*, Vol. 98, No. 11, 2001. This paper defines disability as having difficulty with one or more activities of daily living (ADLs). Lewin applied these age-adjusted trends to the estimates of disability, which are defined as requiring assistance with two or more ADLs. Separate analysis of National Long Term Care Survey data performed by The Lewin Group indicates that these two measures of disability, while different, experienced similar trends from 1982 to 1999.

³ For Medicaid Waiver services, the Department projected forward from actual use through January 2003.

Tables 4 and 5 indicate the number of “users” for each program or service. Statewide projected use for 2005 and 2010 is based on the State’s actual use in 2000, projected forward. Estimates of use in Tables 4 and 5 differ from those in Tables 0 and 1 in two important ways. First, Tables 4 and 5 show the number of users of specific types of service. “Users” in these tables may be served by more than one program, and therefore would not sum to the unduplicated total number of “people” shown in Tables 0 and 1. Second, unlike Tables 0 and 1, county-specific projected use for 2005 and 2010 is based on each county’s actual use in 2000, projected forward.

Demographics and Need

The Vermont population as a whole is projected to grow 8% this decade. Although the number of Vermont children and those under 40 will decline, all other age groups will increase. The fastest growing group is the eldest cohort, those 85 years old and older, which will expand 27% between the years 2000 and 2010. As illustrated in the table below, this group of elders is relatively small in number; nevertheless, they have the greatest need for long term care services.

VERMONT PROJECTED POPULATION GROWTH*

Age	2000 Actual	2005 Projected	2010 Projected
Under 18	147,523	143,274	132,683
18-39	180,529	172,520	170,783
40-64	203,265	239,179	264,459
65-74	40,683	41,862	47,592
75-84	26,831	29,757	31,231
85+	9,996	11,283	12,708
Total	608,827	637,875	659,456

The table below depicts the percent change in the population by age group. For example, the number of elders 85 and older will grow 13% in the first half of the decade and an additional 13% in the second half. The number of children will decrease 3% initially and then another 7%, ending the decade with roughly a 10% decrease.

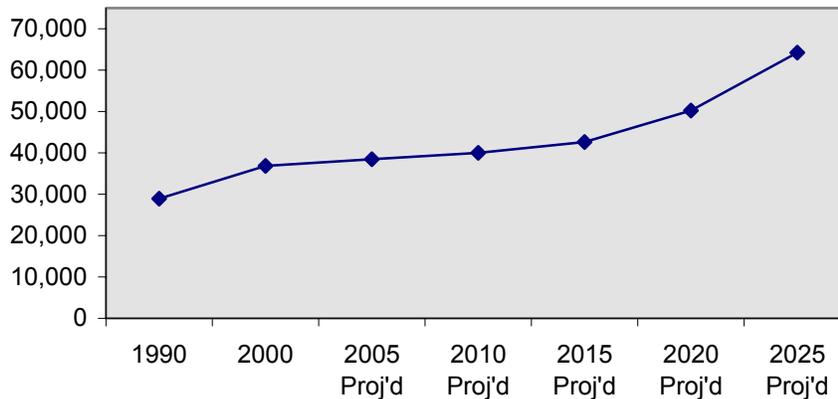
Projected Percent Change in Population over Five Year Period*

Age	2000 to 2005 Projected	2005 to 2010 Projected
Under 18	-3%	-7%
18-39	-4%	-5%
40-64	18%	11%
65-74	3%	14%
75-84	11%	5%
85+	13%	13%
Total	5%	3%

* U.S. Census, Vermont 2000 for "Actual"
MISER for "Projections"

The “baby boom” generation will have a dramatic effect on the long term care system but not until 2020 will society witness the beginning of this widely heralded phenomenon. “Baby boomers” are generally considered to be those people born between 1946 and 1964. Assuming that many people need support and services by their mid-seventies, the oldest “baby boomers” (born in 1946) will begin to require services in 2020, while the youngest will turn 76 in 2040. Demand will not peak until after 2030, when the oldest “baby boomers” turn 85.⁴

VT Elderly Population Growth - Age 75+



As the population has aged, it has become healthier. Recent national findings show a decline in the disability rate for people 65 years old and older.² This decline is attributable to a number of factors: improvements in health, nutrition, and medical treatments; a shift away from manual labor; new medical technologies; lifestyle changes; and improved socioeconomic status, especially with regard to education. Studies have shown that more educated individuals have a disability rate half that of less educated people.

The Department’s model predicts a decline in the disability rate of almost 1% annually for Vermonters aged 65 and older during the period 2000-2005. This decline continues for the second half of the decade, slowing only slightly to -0.8%. (See table below.) (See Appendix, Assumptions Sheet.)

Trends in Vermont Disability Rates:
Projected *Annual* % Change in
Per Capita Disability Rates

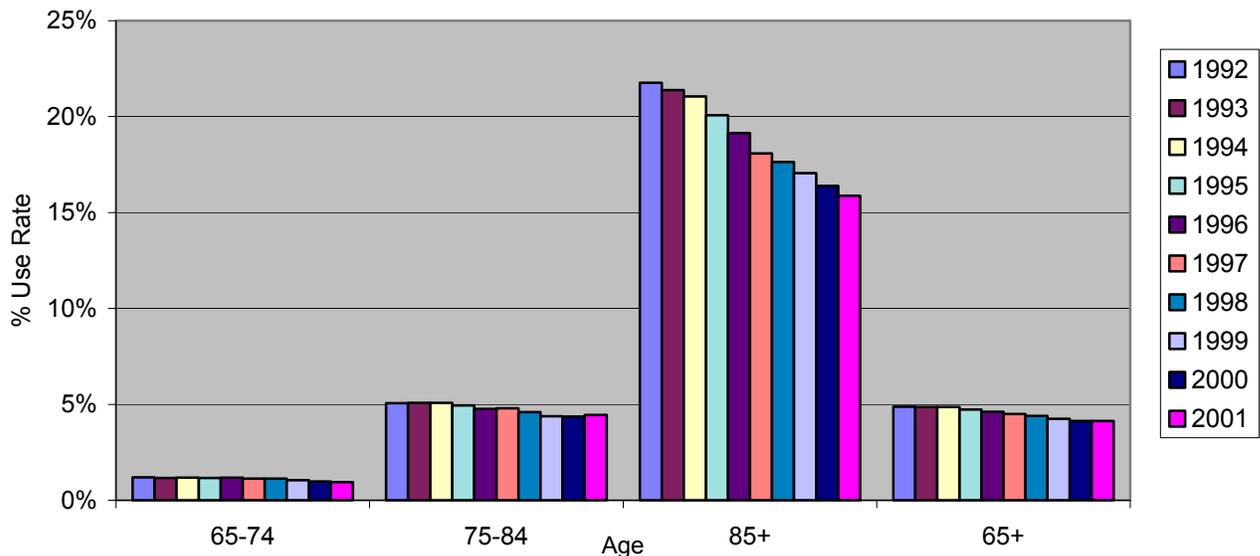
Age	2000-2005	2005-2010
Birth-64	3.8%	2.6%
65+	-0.9%	-0.8%

⁴ Redfoot, Donald L, and Pandya, Sheel M, Before the Boom: Trends in Long-Term Supportive Services for Older Americans With Disabilities. *AARP Public Policy Institute Issue Paper, #2002-15* (October 2002)

For younger adults with physical disabilities, the disability trend is on the rise. The prevalence of disability will climb by almost 4% annually for the first half of the decade and another 2.6% annually for the second half. (See table above.) Disability rates for younger adults are expected to grow in part because of improved medical care that has allowed children with disabilities to survive birth and early childhood, and allowed adults with disabilities to live longer.

Nursing home use in Vermont has dropped significantly since Act 160 became law. The Department's aggressive efforts to improve and expand home and community-based services have contributed to this decrease. In 1996, there were 3,600 people in nursing homes; today there are 3,200. For Vermonters aged 85 and older, nursing home utilization has shown an unusually dramatic decline. (See chart below.) In 1992, approximately 22% percent of Vermont's 85+ year olds lived in nursing homes. Only 16% resided there in 2001.

Percent of Vermont Elders Residing in Nursing Homes
By Age 1992-2001



This striking drop in nursing home use is expected to continue into the future. For example, the percent of elders aged 85+ using nursing homes is projected to decline 4.3% annually from 2000 to 2005, and 3.8 percent annually from 2005 to 2010. These declines are particularly noteworthy given that the 85+ age group makes up nearly half of Vermont's nursing home population. The Department's model assumes the other age groups will experience similar declines. (See table below.) These trends are based on an analysis of Vermont's actual nursing home use during the period 1992-2002, and assume a gradual slowing of the declining trend through 2010. (See Appendix, Assumptions Sheet.)

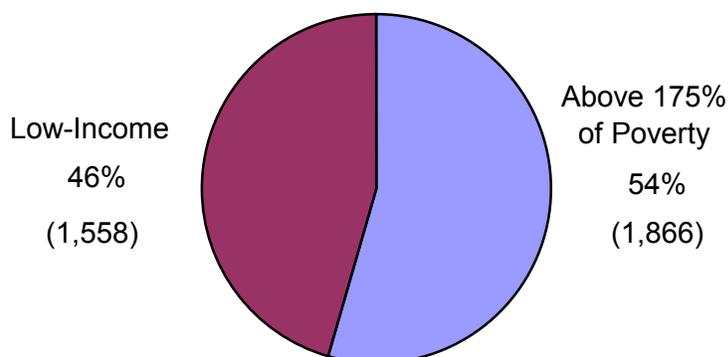
Trends in Vermont Nursing Home Use Rates:
 Projected *Annual % Change* in Per Capita
 Nursing Home Use Rates

Age	2000-2005	2005-2010
Birth-64	-1.7%	-1.1%
65-74	-3.6%	-2.9%
75-84	-3.1%	-2.3%
85+	-4.3%	-3.8%

The delay in demand, coupled with the projected declines in both elder disability and nursing home use, suggest that the need for institutional services will decrease over the next two to three decades. In contrast, the demand for home and community-based care is burgeoning. (See Appendix, Table 4, for growth rates.)

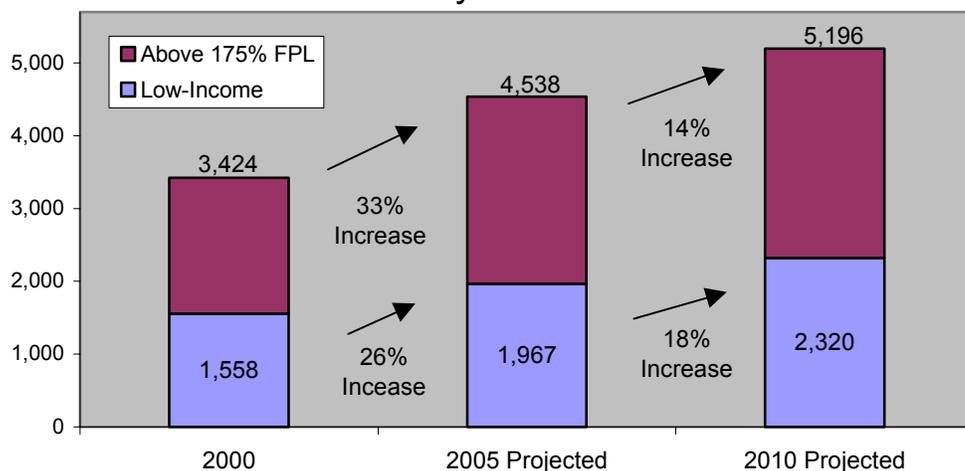
In 2000, there were over 3,400 Vermonters living in the community who required assistance with at least two activities of daily living (ADLs). Almost half (46%) of those individuals were low-income [below 175% of the Federal Poverty Level (FPL).] These numbers reveal the close connection between disability and poverty, and underscore the importance of a publicly funded long term care system. (See chart below.) (Excludes people under 18 years old and those with mental retardation and developmental disabilities.)

VT Community Residents with 2+ ADL's
 Total 3,424 in 2000



The following chart shows the growth in the number of people living in the community who will need long term care. By 2010, the total will expand to 5,196, a 52% increase from 2000.

Number of VT Community Residents w/ 2+ ADL's
By Income

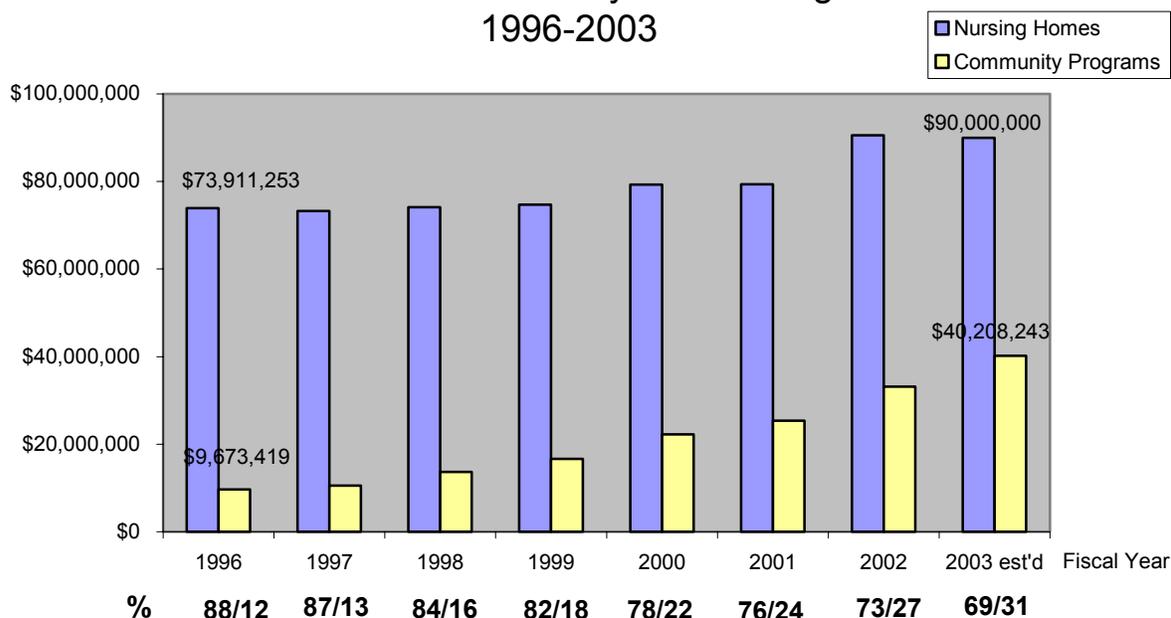


Note: The Department defines a “person with long term care need” as someone who needs assistance with two or more activities of daily living (ADLs). This measure approximates the Department’s definition of “nursing home level of care” (in keeping with eligibility criteria for many of its programs), and captures those people most in need of long term care services. The Department chose 175% of the Federal Poverty Level as the definition for “low-income” because it embraces the majority of Vermont’s publicly funded long term care clients. However, some of the publicly funded programs do serve people who are above 175% of the Federal Poverty Level.

SHIFTING THE BALANCE 2003

Act 160 affords people the opportunity to receive services in the setting of their choice. Its impact on Vermont's long term care system can be measured by the public dollars spent over the last 7 years. A comparison of expenditures for nursing homes with those for home and community-based care reveals two trends. The first is the steady and continuous growth of home and community-based programs. The second is the growing *share* of public long term care dollars spent on home-based programs. In FY 1996, prior to Act 160's implementation, only 12% of the public long term care dollars spent that year paid for home and community-based care; 88% was spent on nursing facilities. For FY 2003 (estimated), 31% of total expenditures is dedicated to alternative care compared with 69% for institutional services. (See chart below.)

Comparison of Public Expenditures for Nursing Homes
and Home & Community-Based Programs
1996-2003

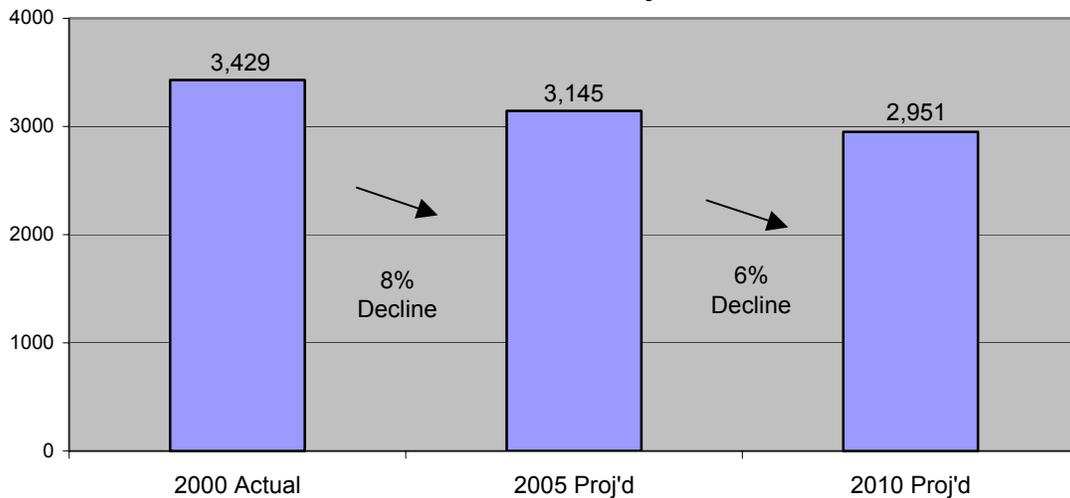


Since home-based services are less costly than nursing home care, Act 160 has allowed Vermont to serve more people for significantly less money. Utilizing saved dollars, the Department has been able to invest in the following programs:

- Adult Day Programs
- Area Agencies on Aging
- Dementia Respite
- Residential Care Homes
- Attendant Services
- Home Modification
- Supportive Services in Public Housing
- Flexible Funds

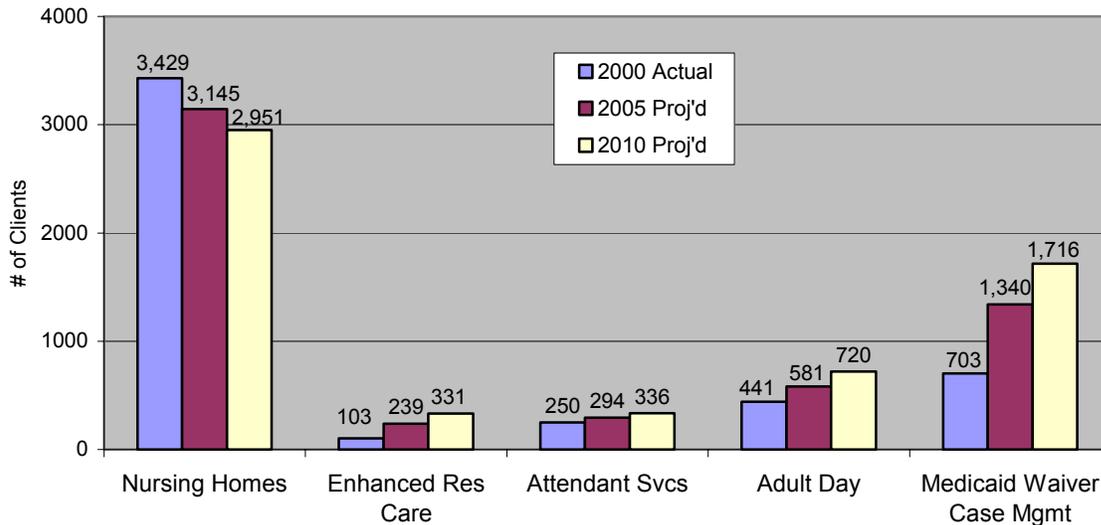
At the same time, Vermont has maintained its high quality of care in nursing homes. The average Medicaid daily rate for nursing home care has risen from \$100 in 1996 to \$139 in 2003. The current average annual Medicaid reimbursement for a nursing home resident is \$50,000. As anticipated, the shift to home-based care has had an effect on nursing home use. Since 1996, nearly 200 nursing home beds have closed and over 300 remain empty. At the conclusion of 2002, almost 25% of Vermont's nursing homes had occupancy below 90%. This decline in the number of nursing home residents is projected to reach nearly 500 by 2010. (See chart below.)

Vermont Nursing Home Residents
Actual and Projected



People who would otherwise have been served in nursing homes are now being served at home by a variety of community-based programs. The following chart shows the projected increase in use of four selected programs compared with the declining use in nursing homes. Note that the projected numbers for community-based programs are based on actual use in 2000³, projected forward. Because actual use of community-based programs in 2000 was less than the need, these projections are conservative and considered a minimum for growth.

Use of LTC Services--Actual and Projected*



*Some of these clients are served by more than one program.

Even as these home and community-based services grow, nursing homes continue to try to fill empty beds. There is little the State can do to prevent increased spending in nursing homes because nursing home care is an entitlement under the Medicaid program. The Home and Community-Based Medicaid Waiver program, however, is limited to a certain number of prioritized slots. People who cannot access home-based services (due to unavailability) must enter nursing homes to receive care.

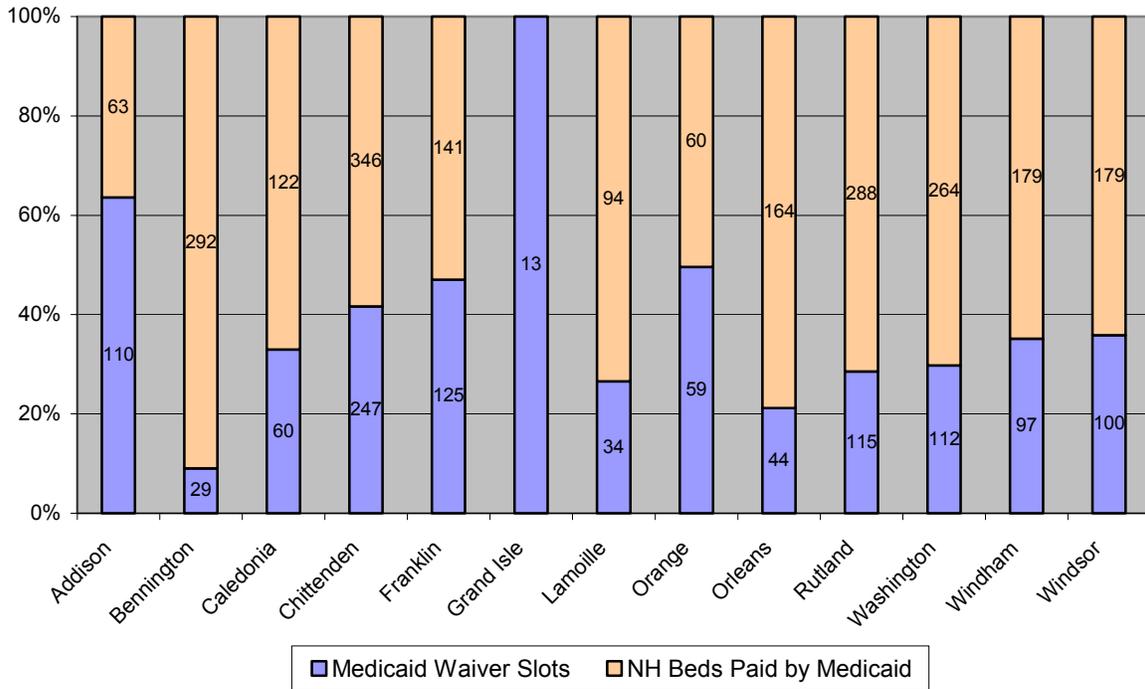
Unless Vermont finds a way to control the nursing home Medicaid entitlement, people will enter nursing homes for lack of alternatives, siphoning funds away from home and community-based services. Since providing nursing home care to an individual is, on average, much more expensive than home-based services, the State could begin to lose ground in its efforts to “shift the balance,” resulting in fewer people being served in the community.

The time has come to better manage Vermont’s long term care resources. In the spirit of Act 160 and long-standing public policy consensus, the State needs to strike a better balance between the number of Home and Community-Based Medicaid Waiver slots and the number of Medicaid funded nursing home beds.

The Department proposes that, in every county of the State, we establish a balance of no less than 40 Home and Community-Based Medicaid Waiver slots for every 60 Medicaid funded nursing home beds.

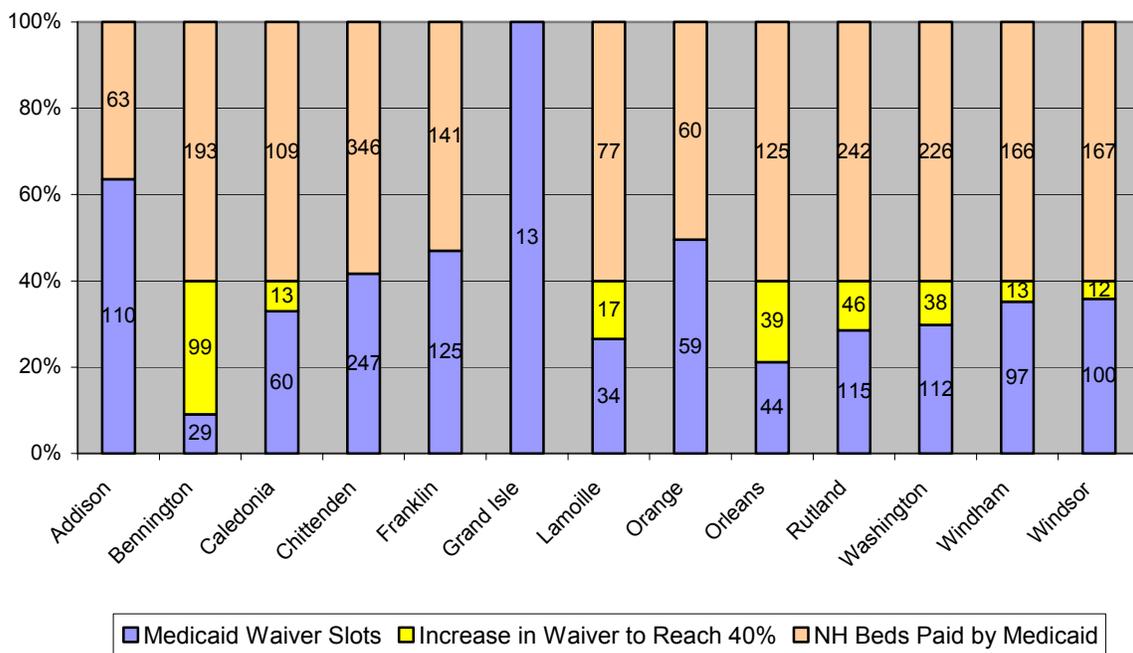
This balance has already been achieved in Chittenden, Franklin and Orange Counties. Addison County has exceeded this balance with 63 Medicaid funded nursing home residents and 110 Home and Community-Based Medicaid Waiver participants at the close of 2002. (See chart below.)

Medicaid Waiver Slots & Nursing Home Beds (Medicaid) By County



The chart below indicates the Medicaid Waiver slot increases (and corresponding decreases in nursing home use) needed to achieve the 40/60 balance in each county. (See highlighted numbers.) If this balance were achieved in 2003, the benefits would be significant. An additional 277 people would be served on the Medicaid Waiver with a savings of \$8,500,000 in the Medicaid nursing home budget. These savings could then be reinvested in alternative services.

Medicaid Waiver Slot Increases Needed to Achieve 40/60 Balance



The Department's goal has been to manage the system within available resources, provide individuals with the options they prefer, and continue the vision of Act 160. To do this, Vermont needs to make a commitment to control the nursing home Medicaid entitlement and achieve at least a 40/60 balance of Medicaid Waiver slots to Medicaid funded nursing home beds. Once this goal is realized, Vermont can begin to plan for a 50/50 balance.

Special Needs Housing

Recommendations:

- **Continue to help communities develop affordable Assisted Living;**
- **Continue to help implement the 2000 Home Modification Study;**
- **As funds permit, raise the ACCS* rate for Assisted Living and residential care homes to at least \$50 per day;**
- **Continue to promote shared housing;**
- **Develop an adult family care program as a Medicaid Waiver option; and**
- **Develop one other group-directed congregate housing site similar to South Burlington Community Housing (Anderson Parkway).**

Affordable, accessible housing with supportive services is one of the two most important requirements for a successful home and community-based service system. (The other is an adequate supply of well-trained, sufficiently paid caregivers.) While Vermont has made significant progress in developing new models, there remains a shortage of affordable housing alternatives. There are individuals residing in nursing homes today, not because their care needs require it, but because they could not find or afford housing with supportive services.

The Department's goal is to help individuals remain at home for as long as possible. As people age or become disabled, living independently may become too great a challenge causing them to seek out a supportive or congregate setting. Others may want a more structured environment such as a residential care home, where room, board, personal and nursing care, assistance with medications, and meals are provided. Shared housing offers yet another opportunity for those who want to share their home with someone who could assist them. Regardless of the setting, people want to receive needed care, remain as independent as possible, and avoid future moves.

Assisted Living: Assisted Living is defined in Vermont regulations as “a program that combines housing, health, and supportive services for the support of resident independence and aging in place. Within a homelike setting, assisted living units offer, at a minimum, a private bedroom, private bath, living space, kitchen capacity and a lockable door. Assisted living promotes resident self-direction and active participation in decision-making while emphasizing individuality, privacy and dignity.”

* Assistive Community Care Services in the Medicaid State Plan

The intent of Assisted Living is to provide people with private homelike space where they can live with dignity while “aging in place” despite increased care needs. The recently promulgated Vermont regulations extend the capacity of Assisted Living to care for people who might otherwise be served in a nursing home. These regulations, however, establish reasonable limits on aging in place.

Enhanced Residential Care. Vermont needs to expand its current Enhanced Residential Care Home program that allows nursing home eligible people to remain in licensed Level III residential care homes as participants in the Home and Community-Based Medicaid Waiver program. Projections from the model indicate that Vermont needs to develop over 100 more Enhanced Residential Care beds by 2005 and another 100 by 2010 for a total of 331. (See Appendix, Table 4.) Since these projections are based on utilization of the program in its early years, they most likely underestimate future demand.

The Department hopes to develop a statewide adult “**Family Care Program**” as a Medicaid Waiver option by 2005. Individuals would be cared for in the home of a qualified caregiver.

Group-directed congregate living arrangements such as South Burlington Community Housing (Anderson Parkway) provide individual apartments and shared caregivers for a small number of significantly disabled younger adults. The Department hopes to replicate this housing model in at least one other site by 2010.

Shared housing has become increasingly popular in many parts of Vermont. The Department will work to preserve group-shared residences such as the Ruggles House in Burlington and Evergreen Place in Waitsfield. Match-up services like those offered by HomeShare Vermont (matching the client with the home) need to be more widely available throughout the State.

Home Modification. Physically accessible renovations can be an enormous boon to an individual with a disability or an elder. Often, an accessible entrance and bathroom are key factors in enabling a person to remain at home. The Vermont Center for Independent Living has managed a Home Accessibility Program for many years, although this program is grossly under-funded. (There was a three-year wait for home modification assistance in 2002.) The annual allocation for this program needs to grow an additional \$660,000 over the 2000 funding level. These added dollars would provide an average of 50 people with appropriate and quality home modifications. In addition, the Department needs to continue educating builders and architects on the importance of new construction being either “universal design” or easily adaptable. As the population ages, home accessibility will become more critical. To the extent possible, the State should anticipate and prevent expensive retrofitting.

Reverse Mortgages are federally guaranteed loans to elder homeowners, secured by the equity of their home. These loans allow elders to remain in their homes by creating a cash flow for necessary care and related expenses. The loan is paid off when the house is sold.

Vermont's housing community is partnering with the Department to develop various housing options for seniors and adults with physical disabilities. The Department of Aging and Disabilities is currently working with the Department of Housing and Community Affairs to develop a common data set of housing needs to guide both agencies' planning for these two populations. This data set should be available in 2003 and will be incorporated into the 2004 version of this report.

Caregivers

Recommendation:

- **As funds permit, continue to improve wages and benefits for personal caregivers in all settings until caregivers receive a *starting* wage of at least \$10/hour, along with basic benefits such as health insurance, sick time and vacation leave; and**
- **Increase wages in all settings by an annual inflation factor.**

In order to remain independent, many elders and adults with physical disabilities require significant personal care (assistance with dressing, bathing, movement, toileting, eating). Unfortunately, a shortage of personal caregivers persists across all settings—nursing homes, residential care homes, adult day services, home health, as well as for people who hire their own caregivers. This shortage will only grow worse as the population ages and as opportunities to help people remain at home expand. Low wages and inadequate or non-existent benefits are primarily responsible for the shortage. Compounding this problem are the work place environment and the manner in which personal caregivers are treated.

The Department convened a task force to develop solutions. This group issued a report in 2001 after surveying over 1,050 personal caregivers from a variety of settings. The report lists over 30 recommendations, many of which are currently being implemented.

Progress so far includes:

a. Significant wage improvements

- Over the last several years, nursing homes have received nearly \$8 million for a “wage supplement”; these funds must be directed to employee salaries and benefits. As a result, the average wage for nursing home Licensed Nursing Assistants has increased to \$10.41/hour, up from \$8.14/hour in 1998.
- In the Home and Community-Based Medicaid Waiver program, caregiver wages for the “consumer-directed” and “surrogate-directed” options (participants hire their own caregivers) rose to \$10.00/hour. These personal caregivers do not receive any benefits.

- In the Attendant Services Program, the 2002 starting wage increased to \$8.00/hour. After 6 months of employment, the hourly wage rises to \$8.50. These personal caregivers receive no benefits.
 - In Home Health Agencies, the average wage has grown to \$10.74/hour for Licensed Nursing Assistants, up from \$8.24 in 1998. Licensed Nursing Assistants receive benefits.
- b. The Task Force Sub-committee on Best Practices is working with providers, especially home health agencies and nursing homes, to gather and disseminate “best practices” for recruiting and retaining personal caregivers. The Department is also collaborating with providers on a certification process to identify and publicize those providers who adhere to best practices.
 - c. The Department has contracted with the Community of Vermont Elders (COVE) to develop a Professional Caregiver Association that can provide organizational support to personal caregivers.
 - d. The Department conducted a study to determine both the range of preferred benefits and mechanisms to finance them. The study was informative, however, the biggest obstacle to providing benefits remains the lack of funds.

In the current and foreseeable fiscal environment, any wage increases for community-based caregivers will be incremental at best. Nonetheless, every effort should be made to inflate wages annually, similar to the mandated nursing home annual inflation adjustment. Savings from decreased nursing home utilization could be used to attain this parity.

In addition, Vermont needs to develop a public information campaign that underscores the importance of caregiving and promotes its attributes as an occupation. Once wage, benefit and working conditions improve, more people will be drawn to this important work.

Finally, the State needs to continue to maximize the involvement of family, friends and neighbors as caregivers while simultaneously supporting their efforts. Currently, the Department promotes their involvement through the Home and Community-Based Medicaid Waiver and Attendant Services Program, and supports their efforts through its respite programs and the new National Family Caregiver Support Program.

Adult Day Services

Recommendation:

- **Increase the capacity of adult day centers to serve 1,500 people in 2010, up from 800 in the year 2000. This reflects an increase in daily capacity from 441 to 720.**

As demand has grown to help nursing home eligible people remain at home, adult day programs have come to play a crucial role. Centers offer a full day's care and supervision of participants while furnishing much needed respite to family caregivers. Adult day centers currently provide intensive personal care and increased nursing services in addition to activities, socialization and meals. When used in combination with other home-based services, adult day centers now offer a true alternative to nursing home care.

Adult day services have played a pivotal role in helping many people remain independent and at home. However, the capacity of the existing adult day centers is limited. Many are full today and unable to accept new participants. Some centers have expanded to multiple sites but many more are needed. For the purpose of this plan, adult day service capacity needs to nearly double by 2010.

The Department has developed new funding streams for adult day services and raised the hourly Medicaid reimbursement rates. As a result, total State funding for these services has increased from \$838,905 in 1997 to \$2,842,000 in 2002, a 240% increase.

Growing participation in adult day programs demonstrates the strong demand for this service. Since 1997, the annual number of adult day participants has grown 45%, from 677 to 978. Such growth, however, has not kept pace with demand. Addison County has expanded its capacity and now serves more than 20% of the State's adult day participants (see Appendix, Table 5), yet has only 5% of the State's disabled population over 65 years old. (See Appendix, Table 3a.) If the adult day capacity in other counties were expanded to match that of Addison County, Vermont would see a deluge of new participants.

Reaching the recommended capacity of serving 1,500 people annually in 2010 will be a challenge. Region by region, the Department will quantify the demand for expanded adult day services and work with the centers to identify new funding sources.

Case Management

Recommendation:

- **Expand the capacity of the Area Agencies on Aging to provide case management to more elders; and**
- **Develop a program to provide case management to adults with physical disabilities between the ages of 18 and 60 who do not qualify for such assistance from any other program.**

Case management is the cornerstone of Vermont's community-based system of care. Case managers from the Area Agencies on Aging and Home Health Agencies ensure that people receive the services they need. Case management programs, in conjunction with Home and Community-Based Medicaid Waiver teams and good coordination at the local level, have resulted in a strong system of care. This structure promotes favorable outcomes and program accountability while avoiding unnecessary duplication.

Area Agencies on Aging (AAA's) have long been advocates for the independence of elders. AAA's currently provide case management to approximately 8,000 elderly Vermonters annually, regardless of income. Clients are prioritized by "greatest social and economic need." Case management services range from intermittent oversight to intensive daily intervention. Over the last few years, the Department and the AAA's have worked collaboratively to foster professional development of AAA staff. Case management standards are now in place requiring all case managers to pass a certification exam.

All participants in the Home and Community-Based Medicaid Waiver program receive case management from either Area Agencies on Aging or Home Health Agency staff. Each Waiver participant has one case manager who is responsible for ensuring that the client's needs are identified and met in accordance with the person's preferences. Reimbursement rates for this vital service have been increased over the past few years.

As the elder population grows, there will be increasing demand for case management. However, most of the AAA case management funds come from the federal Older Americans Act. The Act promises minimal funding growth in the future, which will create pressure on State funds. Hopefully, nursing home savings can help support the growing need for AAA case management.

A significant gap in the system is the lack of case management services for adults with physical disabilities. Individuals between the ages of 18 and 60 have no mandated case management assistance if they are not participants in the Home-Based Medicaid Waiver program. The Department would like to address this long unmet need by utilizing \$100,000 in nursing home savings, matched with Medicaid dollars, to establish a statewide case management program for this population.

Prevention

Recommendation:

- **Expand community-based health promotion and disease prevention programs for elders and adults with physical disabilities.**

Prevention activities and promotion of healthy living can have a dramatic effect on the overall health of elders and adults with physical disabilities. In addition to improving quality of life, such efforts have the potential to reduce health care expenditures.

The declining prevalence of disability among elders is due, in part, to elders simply taking better care of themselves. Health promotion and disease prevention efforts, including improved nutrition and increased physical activity, can help delay the onset of chronic conditions and age related disabilities. Area Agencies on Aging have taken the lead in promoting “successful aging” by expanding access to adequate nutrition through community meal sites and home delivered meal service. In addition, AAA’s have also developed walking clubs, classes in resistance training, computer courses, and arts and crafts programs.

Successful aging applies to adults with physical disabilities as well. Often, a physical disability can prevent an individual from accessing preventive health care, exercise, or community activities. To address this, the Department recently obtained a three-year grant from the Centers for Disease Control to improve access to health promotion and disease prevention programs as well as prevent secondary disease conditions in people with disabilities. Partners in this effort include the Department of Health, the Department of Developmental & Mental Health Services, and Vermont Health Access among others.

The Department routinely gathers data on the health and social well-being of Vermont elders and adults with physical disabilities. These data allow the Department to target health promotion and disease prevention programs to Vermont-specific behavioral health risks. Evaluating Vermonters’ physical and mental health, overall well-being and quality of life, this annual report is published and distributed at the Department’s yearly “Successful Aging and Independent Living” (SAIL) Summit.

FUTURE STEPS

1. Obtain Vermont population projections through 2020 and incorporate them into the 2004 report.
2. Analyze and incorporate the U.S. Census 2000 disability data from the Public Use Microdata Sample, which should be available in mid-2003.
3. Continue to gather data on the incidence of specific disability conditions among Vermonters.
4. Gather and incorporate data on Home Health Agency services. This information is not easily obtainable because data sets do not match. However, the Department expects to have preliminary data in 2004.
5. Obtain and incorporate statewide data on in-migration and out-migration of elders and adults with physical disabilities.
6. Obtain data on children with significant disabilities in order to plan for their transition to adult services.
7. Work with the Long Term Care Coalitions, Area Agencies on Aging and other stakeholders to develop county-based plans.
8. In collaboration with the Department of Housing and Community Affairs, establish a joint data set on housing needs for elders and adults with physical disabilities.

APPENDIX

ASSUMPTIONS SHEET

Disability Rate Trends (non - MR/DD)

Annual % change in the disability rate by age group.

	2000-2005	2005-2010
0-64*	3.8%	2.6%
65+**	-0.9%	-0.8%

<i>Default values:</i>		
	'00-'05	'05-'10
0-64	3.8%	2.6%
65+	-0.9%	-0.8%

*Default disability trends for 0-64 population assumes same rate of increase as assumed by the Social Security Administration for Disabled Workers (i.e., individuals receiving Social Security Disability Insurance benefits) from the 2002 Annual Trustees Report. We apply these trends to all individuals younger than age 65, as little good projection data exist for individuals younger than 18.

**Default disability trends for the 65+ population are informed by disability trends reported by Manton from the National Long Term Care Survey. From Manton's age-adjusted trend analysis, we derived that the percentage of individuals having difficulty with 1+ ADL (2+ ADLs were not reported separately) decreased by 1% annually from 1989 to 1999. We assume a slight flattening of this trend in the future.

Nursing Facility Use Rate Trends***

Annual % change in per capita nursing facility use by age group.

	2000-2005	2005-2010
0-64	-1.7%	-1.1%
65-74	-3.6%	-2.9%
75-84	-3.1%	-2.3%
85+	-4.3%	-3.8%

Note: VT historical trends:

	'92-'02	'99-'01	'00-'02
0-64	-1.1%	-5.0%	-2.7%
65-74	-2.9%	-6.0%	-4.6%
75-84	-2.3%	-2.2%	-4.3%
85+	-3.8%	-4.7%	-5.1%

Default values:

	'00-'05	'05-'10
0-64	-1.7%	-1.1%
65-74	-3.6%	-2.9%
75-84	-3.1%	-2.3%
85+	-4.3%	-3.8%

***Includes all payers, i.e., both public and private pay nursing facility residents. Default trend assumptions for 2000-2005 incorporate observed trends in the nursing facility use rate through the second quarter of 2002, after which we assume the same annual trend used as the default for 2005-2010.

Ratio of any disability during year to point-in-time disability

1.00 <--- set at 1 for point-in-time estimates

Table 0

**Comparison of LTC Need¹ (2+ ADLs) and Use² (Nursing Facility or HCBS) by County
 Projected Use Reflects Demographic Changes, but Redistributes Resources to Counties Based on Disability
 Persons Age 18 and Above, All Income Levels
 Point in Time**

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2000															
People with LTC Needs (2+ ADLs) ¹	6,853	306	702	347	1,243	41	426	36	248	225	414	845	758	582	681
People with LTC Use - Actual ²	4,865	265	517	227	816	7	348	12	192	131	318	630	571	400	431
2005															
People with LTC Needs (2+ ADLs) ¹	7,684	350	769	387	1,447	43	482	44	287	250	484	932	812	636	760
People with LTC Use - Projected Based on County's share of 18+ Disabled Pop. ^{2,3}	5,276	241	528	266	993	29	331	30	197	172	333	640	558	437	522
2010															
People with LTC Needs (2+ ADLs) ¹	8,147	388	788	410	1,606	44	514	56	314	272	528	944	813	672	797
People with LTC Use - Projected Based on County's share of 18+ Disabled Pop. ^{2,3}	5,655	270	547	284	1,115	31	357	39	218	189	367	655	564	467	553

¹LTC Needs defined as requiring assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities. Includes individuals in nursing facilities and individuals in the community.

²People with LTC use represent an unduplicated "point-in-time" count of individuals using either a nursing facility or home and community-based services (HCBS). Nursing facility residents represent an average daily census, and include privately and publicly funded nursing facilities. People with HCBS use represent the average monthly number of people with the following *publicly*-funded HCBS: Medicaid Waiver Personal Care, Adult Day, Attendant Services Program, Homemaker Services, Enhanced Residential Care, and ACCS. People with HCBS use must require assistance with 2+ ADLs.

³Projected number of people with use in 2005 and 2010 reflects two key assumptions: 1) each county's projected use is proportional to its share of the 18+ disabled population in the State, and 2) state-wide use trends reflect changes in age-distribution but assume no changes in service patterns beyond Fiscal Year 2003. Specifically, projections of the following Medicaid Waiver services, which experienced rapid growth between FY 2000 and FY 2003, reflect actual known slot use as of February 2003: MW Case Management, MW Personal Care, MW Respite, and MW Enhanced Residential Care. All other services were trended forward from FY 2000 based on changes in the age distribution of the population.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; and county-level data on income and population characteristics from the 2000 Census.

Projected number of community residents with LTC use in 2005 and 2010 is based on 2000-2003 use statistics from VT DAD and trend assumptions from the following sources: VT population projections by age group supplied by VT DAD; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet.

County estimates may not sum to Vermont total due to rounding.

Number of nursing facility residents includes Wake Robin but excludes Arbors and Mertens.

Table 1

Comparison of HCBS Need (2+ ADLs)¹ and Publicly-Funded HCBS Use³ in the Community by County, 2000, 2005, and 2010
Projected Use Reflects Demographic Changes, but Redistributes Resources to Counties Based on Disability
Low Income Persons Age 18 and Above
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Oripleans	Rutland	Washington	Windham	Windsor	
2000																
Need: Community Residents with LTC Needs¹																
All Incomes	3,424	187	243	186	686	41	222	36	123	158	159	400	331	267	385	
Low-Income ²	1,558	83	111	87	310	20	101	16	56	72	77	185	147	121	173	
Use: People Using Publicly-Funded HCBS																
Low-Income ² - Actual ³	1,225	115	47	58	227	5	127	10	55	52	54	160	126	72	117	
2005																
Need: Community Residents with LTC Needs¹																
All Incomes	4,538	239	356	237	918	43	292	44	168	189	240	531	437	358	486	
Low-Income ²	1,967	108	143	110	384	31	129	30	78	91	106	224	177	150	207	
Use: People Using Publicly-Funded HCBS																
Low-Income ² - Projected Based on County's Share of 18+ Disabled Pop. ⁴	1,820	100	132	101	355	29	119	27	72	84	98	207	163	139	191	
2010																
Need: Community Residents with LTC Needs¹																
All Incomes	5,196	283	405	268	1,086	44	336	56	200	214	287	583	481	412	542	
Low-Income ²	2,320	129	167	129	455	40	153	43	99	109	131	251	200	178	235	
Use: People Using Publicly-Funded HCBS																
Low-Income ² - Projected Based on County's Share of 18+ Disabled Pop. ⁴	2,310	128		129	453	40	152	43	99	109	131	250	199	177	234	

¹LTC Needs defined as requiring assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

²Low-Income defined as income below 175% of Federal Poverty Guideline.

³Community residents with publicly-funded LTC use represents an unduplicated count of individuals with 2+ ADLs with any use during the month of the following programs: Medicaid Waiver Personal Care, Adult Day, Attendant Services Program, Homemaker Services, Enhanced Residential Care, and ACCS. 2000 user counts represent estimated number of unduplicated users during the month.

⁴Projected number of people with use in 2005 and 2010 reflects two key assumptions: 1) each county's projected use is proportional to its share of the 18+ disabled population in the State, and 2) state-wide use trends reflect changes in age-distribution but assume no changes in service patterns beyond Fiscal Year 2003. Specifically, projections of the following Medicaid Waiver services, which experienced rapid growth between FY 2000 and FY 2003, reflect actual known slot use as of February 2003: MW Case Management, MW Personal Care, MW Respite, and MW Enhanced Residential Care. All other services were trended forward from FY 2000 based on changes in the age distribution of the population.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; and county-level data on income and population characteristics from the 2000 Census.

Projected number of community residents with LTC use in 2005 and 2010 are based on 2000-2003 use statistics from VT DAD and trend assumptions from the following sources: VT population projections by age group supplied by VT DAD; and assumptions about disability and institutionalization trends entered on ASSUMPTIONS sheet.

Table 2
Estimated Number of People with LTC Needs¹ by County, 2000, 2005, and 2010
By Disability Level and Income
Persons of All Ages
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2000															
Nursing Facility ^{2,3}	3,429	119	459	161	557	-	204	-	124	67	255	444	426	316	297
Community ⁴	603,164	35,810	36,380	29,304	145,641	6,459	44,973	6,901	23,109	28,120	25,644	62,654	57,424	43,838	56,907
All <175% FPL	141,600	7,935	8,852	7,646	32,597	1,794	10,412	1,533	5,443	6,622	7,074	15,657	12,787	10,346	12,904
2+ ADLs	1,617	87	115	90	323	21	106	17	58	74	79	191	152	125	178
1+ ADLs	2,667	143	188	149	537	34	177	28	97	123	131	315	250	205	291
Any ADL or IADL	6,785	364	473	379	1,386	87	449	69	248	310	335	801	633	520	732
All 175%+ FPL	461,564	27,875	27,528	21,658	113,044	4,665	34,561	5,368	17,666	21,498	18,570	46,997	44,637	33,492	44,003
2+ ADLs	2,006	113	140	106	410	22	132	21	72	93	89	229	198	156	225
1+ ADLs	3,523	199	244	184	730	39	235	38	128	163	155	399	346	272	391
Any ADL or IADL	8,846	500	610	460	1,850	97	588	96	322	409	387	999	869	683	977
2005															
Nursing Facility ^{2,3}	3,145	112	413	149	529	-	190	-	118	61	244	402	375	278	275
Community ⁴	632,996	37,788	37,318	30,421	154,740	6,468	48,092	8,007	25,259	29,397	26,994	63,880	59,782	45,825	59,025
All <175% FPL	148,256	8,349	9,087	7,893	34,716	1,791	11,090	1,764	5,921	6,878	7,441	15,966	13,229	10,755	13,377
2+ ADLs	2,036	112	147	113	400	32	135	31	81	95	109	231	183	155	213
1+ ADLs	3,237	177	230	179	653	46	216	44	126	149	172	369	291	246	339
Any ADL or IADL	8,017	436	557	441	1,670	103	533	95	307	363	421	924	718	606	841
All 175%+ FPL	484,740	29,439	28,232	22,528	120,024	4,677	37,002	6,243	19,338	22,519	19,553	47,915	46,553	35,070	45,648
2+ ADLs	2,736	141	223	135	576	13	178	16	97	106	141	322	276	219	294
1+ ADLs	4,496	243	341	225	961	31	299	37	163	186	220	514	443	352	482
Any ADL or IADL	10,676	597	760	539	2,305	94	713	111	396	470	500	1,192	1,031	824	1,146
2010															
Nursing Facility ^{2,3}	2,951	106	384	142	520	-	179	-	114	59	241	360	331	260	255
Community ⁴	654,690	39,206	37,562	31,052	162,605	6,378	50,821	9,178	27,292	30,229	28,009	63,991	60,926	47,199	60,242
All <175% FPL	152,791	8,630	9,124	8,000	36,499	1,761	11,675	2,014	6,366	7,033	7,702	15,934	13,395	11,025	13,633
2+ ADLs	2,392	133	171	133	473	41	160	44	102	113	134	257	207	182	241
1+ ADLs	3,723	206	261	205	764	56	251	61	154	173	205	405	322	283	378
Any ADL or IADL	9,080	498	618	496	1,945	116	610	127	366	414	492	1,001	783	687	928
All 175%+ FPL	501,899	30,576	28,438	23,052	126,106	4,617	39,146	7,164	20,926	23,195	20,307	48,057	47,531	36,174	46,609
2+ ADLs	3,050	164	246	147	677	6	199	15	108	112	163	348	297	245	321
1+ ADLs	5,009	278	375	245	1,121	25	336	41	185	202	253	553	478	393	526
Any ADL or IADL	11,950	679	833	591	2,681	91	809	135	459	521	571	1,282	1,120	923	1,255

¹LTC needs are defined as requiring assistance with ADLs and/or IADLs. *Excludes* individuals with mental retardation or developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2000 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; and county-level data on income and population characteristics from the 2000 Census.

Table 3-1
Estimated Number of People with LTC Needs¹ by County, 2000, 2005, and 2010
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2000															
Nursing Facility ^{2,3}	3,429	119	459	161	557	-	204	-	124	67	255	444	426	316	297
Community, Low Income (<175%FPL) ⁴	1,617	87	115	90	323	21	106	17	58	74	79	191	152	125	178
<65	454	25	26	23	115	6	32	5	18	20	22	50	40	32	39
<18	59	4	4	3	13	1	5	1	2	3	3	6	5	4	5
18-64	395	22	23	20	101	5	27	4	16	17	20	44	35	28	34
65+	1,163	62	88	67	209	15	74	12	41	54	57	141	112	93	139
65-74	338	18	26	19	61	5	24	4	12	17	17	41	30	26	38
75-84	463	25	33	28	79	6	30	5	16	22	24	58	43	36	57
85+	362	19	28	20	68	4	21	3	13	16	15	42	39	30	43
Community, 175%+ FPL ⁴	2,006	113	140	106	410	22	132	21	72	93	89	229	198	156	225
<65	667	41	38	31	169	7	50	8	26	31	26	67	65	48	62
<18	140	9	8	7	34	1	12	2	5	7	6	14	13	10	13
18-64	527	32	30	24	135	5	38	6	21	24	20	53	52	38	49
65+	1,339	72	102	75	241	16	82	14	47	62	63	162	133	108	164
65-74	303	16	24	16	55	4	20	4	10	15	14	36	29	24	35
75-84	615	33	45	36	106	8	38	7	21	29	31	77	59	49	78
85+	421	22	33	23	80	4	24	3	15	18	17	49	46	35	51

¹LTC Needs defined as requiring assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2000 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; and county-level data on income and population characteristics from the 2000 Census.

Table 3-2
Estimated Number of People with LTC Needs¹ by County, 2000, 2005, and 2010
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2005															
Nursing Facility ^{2,3}	3,145	112	413	149	529	-	190	-	118	61	244	402	375	278	275
Community, Low Income (<175%FPL) ⁴	2,036	112	147	113	400	32	135	31	81	95	109	231	183	155	213
<65	586	33	34	30	148	7	42	7	24	26	29	62	52	42	50
<18	69	4	4	4	16	1	6	1	3	3	3	7	6	5	6
18-64	517	28	30	26	131	6	36	6	22	23	26	56	46	37	44
65+	1,450	79	113	83	252	25	93	24	57	68	80	169	131	113	163
65-74	402	20	33	21	72	6	28	6	16	19	22	46	37	32	43
75-84	540	30	41	34	93	9	35	9	19	26	31	63	45	42	63
85+	509	29	39	29	87	9	30	9	22	23	27	59	48	40	58
Community, 175%+ FPL ⁴	2,736	141	223	135	576	13	178	16	97	106	141	322	276	219	294
<65	859	52	49	40	217	8	66	11	35	39	35	83	85	62	78
<18	165	10	9	8	41	2	15	2	6	8	7	16	15	11	15
18-64	695	42	40	32	176	6	51	9	28	32	28	67	69	51	63
65+	1,877	89	173	96	358	6	112	6	62	66	106	239	191	157	215
65-74	339	16	33	16	63	3	22	3	12	15	17	40	34	27	37
75-84	790	39	73	45	146	5	50	5	25	31	46	98	72	62	92
85+	748	33	67	35	149	(2)	41	(3)	25	20	43	102	85	68	86

¹LTC Needs defined as requiring assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2000 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; and county-level data on income and population characteristics from the 2000 Census.

Table 3-3
Estimated Number of People with LTC Needs¹ by County, 2000, 2005, and 2010
Individuals Needing Assistance with 2+ ADLs
By Age Group and Income
Point in Time

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
2010															
Nursing Facility ^{2,3}	2,951	106	384	142	520	-	179	-	114	59	241	360	331	260	255
Community, Low Income (<175%FPL) ⁴	2,392	133	171	133	473	41	160	44	102	113	134	257	207	182	241
<65	698	39	39	36	178	8	51	9	30	31	35	72	62	49	58
<18	72	4	4	4	18	1	7	1	3	3	3	7	6	5	6
18-64	626	35	35	32	160	7	45	8	27	28	32	65	55	45	52
65+	1,694	94	132	97	295	33	109	35	71	82	99	186	145	133	183
65-74	488	25	40	25	87	7	33	9	21	23	29	54	44	40	51
75-84	572	32	44	35	102	11	37	11	21	29	33	64	47	44	63
85+	634	38	48	38	106	15	38	15	29	31	38	67	54	49	69
Community, 175%+ FPL ⁴	3,050	164	246	147	677	6	199	15	108	112	163	348	297	245	321
<65	1,007	62	56	46	259	8	79	14	43	46	41	94	98	72	90
<18	174	11	9	8	45	2	17	2	7	8	7	16	16	11	15
18-64	833	51	47	38	214	7	62	11	36	38	33	78	82	61	75
65+	2,043	103	190	101	418	(3)	120	1	65	66	123	254	199	173	231
65-74	365	19	35	15	70	1	23	3	14	16	19	42	37	30	41
75-84	811	41	79	44	161	3	51	5	25	31	47	97	74	64	90
85+	867	43	76	41	188	(7)	46	(7)	26	20	58	115	89	80	100

¹LTC Needs defined as requiring assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities.

²Represents average daily number of nursing facility residents in fiscal year, based on quarterly MDS data (includes Wake Robin but excludes Arbors and Mertens). Nursing facility residents not broken out by income or disability level because data are unavailable.

³Nursing facility "need" assumes that all individuals in nursing facilities in 2000 "needed" nursing facility care. Trend in nursing facility need over time is based on use trend assumption entered on ASSUMPTIONS sheet. All individuals in nursing homes are assumed to have 2+ ADLs.

⁴Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; and county-level data on income and population characteristics from the 2000 Census.

Table 3a

**Percent Distribution of Community Residents with LTC Needs¹ by County, 2000, 2005, and 2010
Individuals Needing Assistance with 2+ ADLs, by Age Group
Persons of All Income Levels
Point in Time**

	Vermont (100%)	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
Age <18															
2000	199	6.1%	5.9%	4.9%	23.7%	1.1%	8.7%	1.2%	3.8%	4.9%	4.3%	9.9%	9.3%	7.0%	9.2%
2005	233	6.1%	5.6%	4.8%	24.7%	1.1%	9.0%	1.2%	3.9%	4.7%	4.2%	9.6%	9.2%	6.8%	9.0%
2010	246	6.2%	5.4%	4.7%	25.6%	1.0%	9.6%	1.3%	4.1%	4.6%	4.2%	9.3%	9.0%	6.5%	8.6%
Age 18-64															
2000	922	5.8%	5.8%	4.8%	25.6%	1.1%	7.1%	1.1%	3.9%	4.5%	4.3%	10.5%	9.4%	7.2%	8.9%
2005	1,211	5.8%	5.8%	4.8%	25.4%	1.0%	7.2%	1.2%	4.1%	4.5%	4.5%	10.1%	9.5%	7.2%	8.8%
2010	1,459	5.9%	5.6%	4.8%	25.6%	1.0%	7.3%	1.3%	4.3%	4.5%	4.5%	9.8%	9.4%	7.2%	8.7%
Age 18+															
2000	1,121	5.9%	5.8%	4.8%	25.3%	1.1%	7.4%	1.1%	3.9%	4.6%	4.3%	10.4%	9.4%	7.2%	9.0%
2005	1,445	5.9%	5.8%	4.8%	25.3%	1.0%	7.5%	1.2%	4.1%	4.5%	4.4%	10.1%	9.5%	7.2%	8.9%
2010	1,705	5.9%	5.6%	4.8%	25.6%	1.0%	7.6%	1.3%	4.3%	4.5%	4.4%	9.7%	9.4%	7.1%	8.7%
Age 65+															
2000	2,503	5.3%	7.6%	5.7%	18.0%	1.2%	6.3%	1.0%	3.5%	4.6%	4.8%	12.1%	9.8%	8.0%	12.1%
2005	3,327	5.1%	8.6%	5.4%	18.4%	0.9%	6.2%	0.9%	3.6%	4.1%	5.6%	12.3%	9.7%	8.1%	11.4%
2010	3,738	5.3%	8.6%	5.3%	19.1%	0.8%	6.1%	1.0%	3.7%	4.0%	5.9%	11.8%	9.2%	8.2%	11.1%

¹LTC Needs defined as requiring assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities. Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; and county-level data on income and population characteristics from the 2000 Census.

Table 3b

**Distribution of Community Residents with LTC Needs¹ by County, 2000, 2005, and 2010
 Individuals Needing Assistance with 2+ ADLs, by Age Group
 Persons of All Income Levels
 Point in Time**

	Vermont	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor	
Age <18																
2000	199	12	12	10	47	2	17	2	8	10	9	20	19	14	18	
2005	233	14	13	11	58	2	21	3	9	11	10	22	21	16	21	
2010	246	15	13	11	63	3	24	3	10	11	10	23	22	16	21	
Age 18-64																
2000	922	54	53	44	236	10	65	10	36	41	40	97	87	66	82	
2005	1,211	71	70	58	307	12	87	15	50	54	54	123	115	88	107	
2010	1,459	85	82	70	373	14	107	20	63	65	65	143	138	105	127	
Age 18+																
2000	1,121	66	65	54	284	12	82	12	44	51	49	116	105	80	100	
2005	1,445	85	83	70	365	15	108	18	59	65	64	145	137	103	128	
2010	1,705	101	95	82	436	16	130	23	73	77	76	166	160	121	149	
Age 65+																
2000	2,503	133	190	142	449	31	157	26	87	116	119	304	245	201	303	
2005	3,327	168	286	179	611	30	205	29	118	135	186	408	322	270	379	
2010	3,738	197	323	198	713	30	229	36	137	148	222	440	344	306	414	

¹LTC Needs defined as requiring assistance with two or more Activities of Daily Living (ADLs), *excluding* individuals with mental retardation/developmental disabilities. Community residents include individuals residing in non-institutional settings. This includes people living in their homes, as well as people living in residential care and congregate housing with supportive services.

Sources and Notes:

Estimates and projections of LTC need are modeled using data from the following sources: Vermont-specific data on broad disability and population characteristics from the 1990 Census Public Use Microdata Sample (PUMS); national-level information on specific activity limitations from the 1996 panel of the Survey of Income and Program Participation (SIPP); Vermont-specific information income data from the 1999-2001 Current Population Survey, March Supplement; and county-level data on income and population characteristics from the 2000 Census.

Table 4
Actual and Projected Use of Long Term Care Services in Vermont by Program, 2000, 2005,
and 2010¹ Point in Time
Selected Programs/Services

				Growth Rates	
	FY 2000 Actual	FY 2005	FY 2010	2000-2005	2005-2010
Nursing Facilities (Public and Private) ²					
Users	3,429	3,145	2,951	-8%	-6%
Days	104,099	95,477	89,569		
Medicaid Waiver Enhanced Residential Care					
Users	103	239	331	132%	38%
Days	2,585	5,999	8,294		
ACCS (Medicaid State Plan) Residential Care					
Users	361	499	624	38%	25%
Days	11,121	15,384	19,213		
Residential Care Homes -- Private Pay					
Users	1,554	2,022	2,466	30%	22%
Days	47,264	61,514	75,008		
Assisted Living					
Users	ND	ND	ND		
Days	ND	ND	ND		
Medicaid Waiver Personal Care					
Users	639	1,067	1,361	67%	27%
Hours	54,334	90,763	115,699		
Medicaid Waiver Respite					
Users	133	256	332	92%	30%
Hours	5,297	10,181	13,216		
Medicaid Waiver Traumatic Brain Injury					
Users	37	39	41	6%	5%
Hours	25,635	27,204	28,429		
Medicaid Waiver Case Management					
Users	703	1,340	1,716	91%	28%
Hours	1,322	2,520	3,228		
OAA Non-Medicaid Waiver Case Management					
Users	2,442	3,169	3,896	30%	23%
Hours	2,989	3,880	4,769		
Attendant Services Program (ASP)					
Users	250	294	336	18%	14%
Hours	26,995	31,747	36,326		
Adult day					
Users	441	581	720	32%	24%
Hours	6,806	8,967	11,115		
Homemaker Services					
Users	697	1,006	1,305	44%	30%
Hours	1,124	1,623	2,104		
VCIL Home Delivered Meals (disabled clients)					
Users	189	203	214	7%	6%
Meals	2,848	3,054	3,222		
Mental Health and Aging					
Users	147	184	220	25%	20%
Hours	ND	ND	ND		

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2000 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2000 number of Residential Care-Private Pay users was derived by applying an occupancy rate of 90 percent to the known number of RCH-Private Pay beds. User counts for all other services represent the average number of individuals with use during a month. Projections of use assume current use patterns by age, and nursing home trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization, but assume no other changes in LTC policy.

²Nursing facility residents include Wake Robin but exclude Arbors and Mertens.

Table 5-1

Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2000, 2005, and 2010
Selected Programs/Services
Point in Time

Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
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FY 2000 Actual
Number of Users

Nursing Facilities (Public and Private) ³	3,429	119	459	161	557	0	204	0	124	67	255	444	426	316	297
Medicaid Waiver Enhanced Residential Care	103	2	2	1	12	0	21	0	0	5	9	18	15	8	10
ACCS (Medicaid State Plan) Residential Care	361	7	3	15	22	23	28	1	14	13	25	101	74	5	30
Residential Care Homes -- Private Pay	1,554	82	222	49	311	2	96	0	62	56	79	179	186	83	148
Medicaid Waiver Personal Care	639	54	17	26	142	4	71	7	25	21	23	74	64	39	72
Medicaid Waiver Respite	133	19	4	4	39	1	3	3	3	5	12	12	10	5	13
Medicaid Waiver Traumatic Brain Injury	37	0	1	2	3	5	2	0	4	0	1	13	4	2	0
Medicaid Waiver Case Management	703	59	28	14	171	3	91	6	30	20	22	52	77	49	81
OAA Non-Medicaid Waiver Case Management	2,442	111	194	115	400	30	192	63	91	115	108	315	303	160	245
Attendant Services Program (ASP)	250	9	10	12	41	0	23	6	16	18	11	47	20	17	20
Adult Day	441	98	39	17	60	1	27	0	30	18	17	45	34	23	32
Homemaker Services	697	37	32	50	65	11	40	2	37	54	64	81	67	69	88
VCIL Home Delivered Meals (disabled clients)	189	9	14	6	34	1	14	3	8	5	5	32	27	17	14
Mental Health and Aging ⁴	147	18	11	30	10	0	8	0	0	0	0	26	38	6	0

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2000 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2000 number of Residential Care-Private Pay users was derived by applying an occupancy rate of 90 percent to the known number of RCH-Private Pay beds. User counts for all other services represent the average number of individuals with use during a month. Projections of use assume current use patterns by age, and nursing home trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization, but assume no other changes in LTC policy.

²County estimates may not sum to state total because the State provides some services to Vermont residents with mailing addresses outside of Vermont.

³Nursing facility residents include Wake Robin but exclude Arbors and Mertens.

⁴Some counties report Mental Health & Aging clients in groups of counties: Caledonia/Essex/Orleans are listed under Caledonia; Washington/Orange/Lamoille are listed under Washington; and Windham/Windsor are listed under Windham.

Table 5-2

Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2000, 2005, and 2010

Selected Programs/Services

Point in Time

Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
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FY 2005 Projected

Number of Users

Nursing Facilities (Public and Private) ³	3,145	112	413	149	529	0	190	0	118	61	244	402	375	278	275
Medicaid Waiver Enhanced Residential Care	239	20	5	0	38	0	38	0	0	10	17	31	36	25	20
ACCS (Medicaid State Plan) Residential Care	499	8	3	18	32	23	38	1	16	15	46	156	95	8	39
Residential Care Homes -- Private Pay	2,022	89	247	59	425	2	129	0	71	65	122	253	239	129	192
Medicaid Waiver Personal Care	1,067	83	30	39	233	5	121	10	41	31	52	127	115	65	116
Medicaid Waiver Respite	256	34	12	6	72	1	5	5	6	9	27	25	19	12	24
Medicaid Waiver Traumatic Brain Injury	39	0	1	2	3	5	2	0	4	0	1	14	4	2	0
Medicaid Waiver Case Management	1,340	107	42	74	305	0	129	15	49	60	67	141	131	106	114
OAA Non-Medicaid Waiver Case Management	3,169	139	272	144	538	31	240	75	121	135	161	407	381	218	309
Attendant Services Program (ASP)	294	11	11	13	46	0	28	7	18	21	14	60	22	20	22
Adult Day	581	126	55	20	83	1	35	0	41	23	22	57	43	35	40
Homemaker Services	1,006	50	51	68	95	11	58	2	55	67	106	122	97	105	120
VCIL Home Delivered Meals (disabled clients)	203	10	15	6	36	1	15	4	9	5	5	33	29	18	15
Mental Health and Aging ⁴	184	22	15	36	13	0	10	0	0	0	0	33	48	8	0

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2000 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The Fy 2000 number of Residential Care-Private Pay users was derived by applying an occupancy rate of 90 percent to the known number of RCH-Private Pay beds. User counts for all other services represent the average number of individuals with use during a month. Projections of use assume current use patterns by age, and nursing home trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization, but assume no other changes in LTC policy.

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³Nursing facility residents include Wake Robin but exclude Arbors and Mertens.

⁴Some counties report Mental Health & Aging clients in groups of counties: Caledonia/Essex/Orleans are listed under Caledonia; Washington/Orange/Lamoille are listed under Washington; and Windham/Windsor are listed under Windham.

Table 5-3

Actual and Projected Use¹ of Long Term Care Services in Vermont by Program by County, 2000, 2005, and 2010

Selected Programs/Services

Point in Time

Vermont ²	Addison	Bennington	Caledonia	Chittenden	Essex	Franklin	Grand Isle	Lamoille	Orange	Orleans	Rutland	Washington	Windham	Windsor
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FY 2010 Projected

Number of Users

Nursing Facilities (Public and Private) ³	2,951	106	384	142	520	0	179	0	114	59	241	360	331	260	255
Medicaid Waiver Enhanced Residential Care	331	26	7	0	57	0	53	0	0	14	25	40	46	35	27
ACCS (Medicaid State Plan) Residential Care	624	8	4	21	43	24	47	1	18	17	70	200	111	11	47
Residential Care Homes -- Private Pay	2,466	97	269	69	547	2	162	0	81	74	169	311	280	173	232
Medicaid Waiver Personal Care	1,361	103	38	48	301	5	155	13	54	38	78	157	143	84	145
Medicaid Waiver Respite	332	42	17	6	94	1	5	6	8	11	39	31	23	18	29
Medicaid Waiver Traumatic Brain Injury	41	0	1	2	3	5	2	0	5	0	1	14	4	2	0
Medicaid Waiver Case Management	1,716	132	53	91	395	0	162	20	66	73	101	178	164	138	142
OAA Non-Medicaid Waiver Case Management	3,896	170	340	174	686	32	289	97	155	158	216	483	445	279	373
Attendant Services Program (ASP)	336	12	12	14	51	0	32	9	21	24	18	71	24	23	25
Adult Day	720	156	69	24	107	1	43	0	52	28	28	67	51	47	48
Homemaker Services	1,305	63	67	86	127	12	75	3	73	80	152	154	119	141	151
VCIL Home Delivered Meals (disabled clients)	214	10	15	7	39	1	17	4	10	6	6	34	30	19	16
Mental Health and Aging ⁴	220	26	19	42	16	0	12	0	0	0	0	38	57	10	0

¹Individuals may use more than one service. Residents of nursing facilities and Residential Care-Private Pay represent an average daily census. The FY 2000 number of nursing facility residents was derived by averaging quarterly MDS resident counts. The FY 2000 number of Residential Care-Private Pay users was derived by applying an occupancy rate of 90 percent to the known number of RCH-Private Pay beds. User counts for all other services represent the average number of individuals with use during a month. Projections of use assume current use patterns by age, and nursing home trends entered on ASSUMPTIONS sheet. Changes over time therefore are the result of demographic trends and the assumed trends in institutionalization, but assume no other changes in LTC policy.

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