Making a Difference for Elders in the Community

Connecticut Department of Social Services

Caring for Connecticut

Connecticut Home Care Program for Elders

Annual Report To the Legislature

SFY 2006

July 2005 - June 2006

MICHAEL P. STARKOWSKI
Commissioner

STATE OF CONNECTICUT

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November 2, 2007

TO: The Honorable Toni Nathaniel Harp
The Honorable Denise W. Merrill
Co-Chair, Appropriations Committee

Members, Appropriations Committee

The Honorable Jonathan A. Harris
The Honorable Peter F. Villano
Co-Chair, Human Services Committee

Members, Human Services Committee

FROM: Michael P. Starkowski, Commissioner

RE: The Connecticut Home Care Program or Elders Annual Report for SFY 2006

It is with great pleasure that I submit to you the Department`s Annual Report for the Connecticut Home Care Program for Elders. The Connecticut Home Care Program encompasses the State`s long-standing commitment to comprehensive community based care for elder persons in need of long-term care. The State, by providing supportive services at home, has helped to preserve the dignity and autonomy of older persons and has assisted families struggling to maintain older relatives at home.

Development of home care options has helped to curb the spiraling costs of institutionalization, but its most important impact has been on the quality of life for Connecticut's older citizens.

The program combines federal and state funds to efficiently and cost effectively serve elders according to their needs. Actual care plans are developed according to the client`s needs within the limits of 25%, 50% and 100% of the average nursing facility cost. The cost depends upon which Connecticut Home Care Program for Elders functional category corresponds to the individual's needs. This report describes the criteria for each category served by the program.

There were several significant events that occurred in the Home Care program in the past year.

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This past year was the second year of a five-year renewal for the Home and Community Based Services Waiver. The Center for Medicare and Medicaid Services renewed the waiver effective July 1, 2005.

The Department of Social Services continues to work collaboratively with the Department of Community and Economic Development, the Connecticut Housing Finance Authority, the Department of Public Health and the Office of Policy and Management, to develop the Assisted Living Demonstration Pilot Project. By offering assisted living services in the demonstration program, residents are offered a viable choice that will allow them to maintain a degree of continued health, dignity and independence at significantly less cost than a nursing home. Two sites, The Retreat in Hartford and Herbert T. Clark in Glastonbury are fully operational.

In December of 2005, Luther Ridge (45 units) opened in Middletown. The final site, Smithfield Gardens in Seymour opened in November of 2006.

Under Public Act No. 05-209 Section 3, The State Funded Personal Care Assistance Pilot Program, under the Connecticut Home Care Program for Elders was approved to serve 150 persons, sixty-five and older who meet the pilot guidelines and the technical, functional and financial requirements for the home care program. Legislation was passed effective July 1, 2006 approving an additional 100 persons for the pilot, bringing the total number of persons to be served to 250.

As Commissioner of the Department of Social Services, I am proud of the proactive role the Department has taken in developing innovative and effective policies and programs in order to accommodate the needs of our elderly citizens. However, in order to address the growing needs of the increasing number of senior citizens, it is critical that we continue to develop accessible and cost effective services in order to meet these growing needs.

PWC:KB:scs

cc: David Parrella, Director – Medical Care Administration
Matthew Barrett, Director – Public & Government Relations
Kathy Bruni, Manager – Alternate Care Unit

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A. Brief History of the CT Home Care Program for Elders

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J. HUD Facilities Growth

K. Private Assisted Living Pilot Program Growth

L. Assisted Living Demonstration Project Growth

Connecticut Home Care Program for Elders at a Glance

- 16,646 elders were served on the State Funded and Medicaid Waiver portions of the CT Home Care Program for SFY 2006. Calculated with table data. See Page 24.

- $ 115,275,340 in savings were generated as a result of the reduced utilization of nursing facility beds due to the CT Home Care Program`s Medicaid Waiver. See Page 8.

- The monthly average number of clients on the CT Home Care Program for SFY 2006 was 12,895. See Page 22.

- The average monthly cost per client on the State Funded portion of the CT Home Care Program was $ 664 and the Medicaid Waiver portion of the CT Home Care Program was $ 1,298. See Page 10.

- The program expenditures for the Medicaid Waiver and State Funded portion of the CT Home Care Program were $ 198,287,862. See Page 27.

- The number of individuals screened for the CT Home Care Program who were referred for assessment and became clients was 4,192. See Page 15.

- The average length of stay on the CT Home Care Program was 3.3 years. See Page 16.

Program Description and Organization

Through the CT Home Care Program for Elders, the State provides long term care services for older persons who continue to live at home. New developments in the program have increased consumer choice and expanded opportunities for consumers to influence the services which so directly affect their lives. These commitments allow the State to provide long term care in the least restrictive setting to Connecticut's growing population of older adults.

The Department's Alternate Care Unit administers the CT Home Care Program for Elders. The mission of the Alternate Care Unit is to develop a dynamic system that includes a flexible array of cost-effective community based and institutional long term care alternatives, which are responsive to the needs and preferences of individuals and families with continuing care needs.

This mission supports the Department's broader mission to serve families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. Clinical staff from the Alternate Care Unit screen individuals when a need for long term care is identified to assure that the option of home care is considered before institutional care. For a brief history of Connecticut's commitment to home care see Appendix A.

The program is organized under a three-tiered structure, which enables individuals to receive home care services in levels corresponding to their functional dependence and financial eligibility. The first two categories are funded primarily through a State appropriation. Individuals in the third category qualify for reimbursement under the Medicaid Program, therefore, costs for Category 3 are equally distributed between Federal and State funds.

Cost limits for each program category are established so that individual care plan expenditures can increase in response to individual needs. In practice, most actual care plan costs are well under the limits for each category. In Category 3, the category serving the most needy group of elders, the average cost of care is less than half of the cost limit.

The following are descriptions of the three program categories. Eligibility limits and other program requirements are described in more detail later in this report. For a brief summary, please refer to the chart on the organization of the program in Appendix B and the revised legislation in Appendix C.

Category 1: This category is targeted to individuals who are at risk of long term hospitalization or nursing facility placement if preventive home care services are not provided. Since these are not individuals who would immediately need nursing facility placement in the absence of the program, individual care plan limits are set at 25% of the weighted average Medicaid cost in a nursing facility.

Category 2: This category targets individuals who are frail enough to require nursing facility care, but have resources which would prevent them from qualifying for Medicaid upon admission to a nursing facility. Care plan limits for these individuals cannot exceed 50% of the weighted average Medicaid cost in a nursing facility.

Category 3: This category targets individuals who would otherwise require long term nursing facility care funded by Medicaid. In order to assure cost effectiveness, individual care plan costs cannot exceed 100% of the weighted average Medicaid cost in a nursing facility.

This program structure was developed in conjunction with an Ad Hoc Home Care Advisory Committee, which was established by the Department in 1992. Over the years, the Committee has made many critical recommendations, which have resulted in improvements in access to home care. The advice of the Home Care Advisory Committee continues to provide a valuable perspective for the Department's evolving home care program. A complete listing of current members is included in Appendix D.

Assisted Living Services Component

For the past several years the State of Connecticut has been developing alternatives to nursing facility care and assisted living has been a major focus of these efforts. Connecticut has introduced assisted living in state-funded congregate housing facilities, federally-funded HUD residences and is developing new subsidized assisted living in four Connecticut communities.

Assisted living is a special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help with activities of daily living and instrumental activities of daily living. Supportive services are available 24 hours a day to meet scheduled needs in a way that promotes maximum dignity and independence for each resident and involves the resident's family, neighbors, and friends.

Private Assisted Living Pilot

Public Act 02-7 allowed the Department to establish the Private Assisted Living Pilot that became effective January 1, 2003. The Pilot provides seventy-five (75) clients with the opportunity to remain in their private assisted living facility after they have spent down their assets.

The Pilot grew out of recognition that some elders, after living in a Private Assisted Living Facility for a time, have spent down their assets and thus require help with their living expenses. In order to assist these individuals, the Pilot provides funding for their assisted living services. The Pilot does not pay for room and board; it is expected that such individuals will have family members who are willing and able to pick up those expenses. This Pilot is based on the premise

that it will be cost effective for the State to provide for such individuals, for in doing so, they will not require admission to a nursing facility.

As of June 30, 2006, the Private Assisted Living Pilot has served a total of 150 clients at a cost of $2,738,818. This figure includes both core and assisted living service charges and covers a three year period.

State Funded Congregate and HUD Facilities

Public Act 00-2 allowed the Department of Economic and Community Development (DECD) to offer assisted living services to residents in State Funded Congregate Housing and Federally Funded HUD Facilities. Through the collaborative effort of DECD, the Department of Public Health (DPH) and the Department of Social Services (DSS), the program became effective February 2001.

Public Act 00-2 also grants Managed Residential Community (MRC) status to approved State Funded Housing and Federally Funded HUD Facilities for the purpose of providing assisted living services and allows the Department of Public Health (DPH) to waive provisions of the assisted living services agency regulations on a case-by-case basis.

The assisted living services are funded through the State Department of Social Services (DSS) or the State Department of Economic and Community Development (DECD). The assisted living services are provided by an assisted living services agency (ALSA). The assisted living services agency provides the personal care services, core services and supplemental services based on the care needs of the qualified residents.

Assisted Living Services will provide a viable choice to the residents that will enhance and maintain a degree of continued health, dignity and independence at significantly less cost than nursing facility placement.

As of June 30, 2006, 228 clients had received services in State funded congregate facilities at a cost of $3,577,384. This figure includes both core and assisted living service charges and covers a five year period.

As of June 30, 2006, 211 clients had received services in the HUD facilities participating in the assisted living pilot at a cost of $3,731,321. This figure includes both core and assisted living service charges and covers a five year period.

Assisted Living Demonstration Project

Over the past several years, the Department of Social Services in collaboration with the Department of Public Health, (DPH) the Department of Economic Development (DECD) and the Connecticut Housing Finance Authority (CHFA) have been developing the Assisted Living

Demonstration Project which, when fully operational, will provide 300 subsidized assisted living units in both urban and rural settings.

This unique project combines the development financing through CHFA, the necessary housing component through rental subsidies from DECD, and services through DSS' Connecticut Home Care Program for Elders. Four projects have been approved through an initial round of financing, they are in the cities of: Glastonbury, Hartford, Middletown and Seymour.

As of June 30, 2006, 166 clients had received services in the DEMO facilities participating in the assisted living pilot at a cost of $ 2,130,899. This figure includes both core and assisted living service charges over a two year period.

Personal Care Assistance Pilot

The CT Home Care Program for Elders Personal Care Assistance Pilot was approved to serve up to 100 persons age 65 and older who meet all the technical, functional and financial eligibility requirements and for those clients that cannot access adequate home health services.

Persons under age 65 receiving services from the PCA Waiver for persons with disabilities become eligible for personal care assistance services under the CT Home Care Program for Elders when they turn age 65.

Legislation passed in 2006 allows participants on the PCA Waiver turning age 65 to choose between remaining on that program or receive services under the CT Home Care Program for Elders.

As of June 30, 2006, 102 clients had been approved for services and 48 clients were pending.

Care Management and Self Directed Care

Connecticut was a pioneer in the development of quality standards for case management through the State Licensure for Coordination, Assessment and Monitoring Agencies. Just as Connecticut has been a leader in developing this sophisticated model, the State has also been a leader in challenging the limits of case management, or what is now called "care management."

Many frail elders have complex needs which require ongoing coordination and frequent monitoring of their medical, professional, and social services providers. Most clients in the program continue to benefit from the services of an independent care manager.

As shown in the care continuum (Appendix E) some individuals, whether on their own, with family support, or with the assistance of a provider agency, are fully able to coordinate and monitor their own service providers, that is, to manage their own plan of care. These individuals

are considered "self directed" in the Department's model and receive their services under the self directed care component of the program.

As of July 2005, there were 303 active clients who were designated self directed care, representing 2.4 % of the total caseload. By the end of June 2006, there were 262 active self directed care clients representing 2.0 % of the total caseload.

With the recent change in the method used to determine the client's applied income, a large number of clients are now available for review for the self directed care option. Each of these clients were reviewed and offered the self directed care option, as appropriate, over the next year at the time of their annual reassessment.

In August 2001, the ACU field office clinical staff began to target those clients who, upon initial assessment into the program, appear to be candidates for self directed care after an initial six month period of care management services. These clients are reassessed for the self directed care option at the first six month interval rather than after one full year in the program.

In April 2001, the ACU Central Office began logging all self directed care referrals, their source, and disposition in an effort to spur Access Agency referrals and provide documentation of activity. On a scheduled basis, the Department evaluates all individuals in the program for self directed care to insure that only those clients who truly need care management are receiving that service.

Quality Enhancement System

The quality enhancement system in place for the CT Home Care Program for Elders is a system that monitors the unique needs and caliber of services provided to our clients.

Our Quality Enhancement system has 4 teams to provide ongoing monitoring of program functions:

- The Quality Review Team conducts quarterly on-site audits of access agency and assisted living service agency records and visits provider agencies and clients;
- The Peer Review team reviews the process, efficiency, and quality of office operations by a quarterly client record review process;
- The Report Team reviews Access Agency Reports to identify any trends, issues and questions on the reported information. This team monitors the timeliness of information received and provides any necessary follow-up with the Access Agencies; and
- The Training Team visits home health agencies, community service providers, nursing facilities and hospitals and provides information on OBRA requirements and the CT Home Care Program.

The Department of Social Services monitors provider compliance in conjunction with the Department of Public Health. The Community Nursing and Home Health Division within the Department of Public Health conducts annual licensure inspections of all licensed home health agencies. Serious issues of regulatory non-compliance by a licensed agency, which could jeopardize a client's health or safety, are brought to an expeditious hearing; any recommended action is immediately instituted. The Department of Social Services is informed and kept apprised of such actions.

Client satisfaction is considered by the Department of Social Services to be a critical measure of the effectiveness of the Connecticut Home Care Program for Elders. Accordingly, client satisfaction surveys are conducted to assess the program's impact on the participant's life and his/her degree of satisfaction with the services he/she receives. Please refer to Appendix F for results of the Client Satisfaction Survey Report for the Eastern region.

Goals for New Fiscal Year

- To conduct client satisfaction surveys, as our Home Care Program evolves to include choices such as Assisted Living and Personal Care Assistance Services, and to continue to obtain a measure of how our services affect the individual.
- To continue to expand the self directed care component of the Home Care Program by identifying appropriate clients.
- To improve the quality and accuracy of ad hoc program reports with the implementation of our Micro Systems Unit.

COST-EFFECTIVENESS OF THE WAIVER

Program Cost and Projected Savings

In order to establish cost-effectiveness under the Federal Standards for Medicaid Waivers, the Department must only demonstrate that the per capita cost for program participants is less than institutional care. In other words, the Federal Standards assume that every client served by the Waiver would otherwise be institutionalized. Therefore, as long as the cost for each individual's care is less than the cost in a nursing facility, the Waiver program is considered cost-effective.

When the Connecticut Home Care Program for Elder's Waiver was established, the Connecticut General Assembly mandated that the program be designed to be not only cost-effective on an individual basis but also cost-neutral overall. Section 17b-342(a) of the Connecticut General Statutes specifically provides that:

> The program shall be structured so that the net cost to the state for long term facility care in combination with the community based services under the program shall not exceed the net cost the state would have incurred without the program.

To meet the General Assembly's higher standard for measuring cost effectiveness under the Waiver, it is critical that the Department's cost analysis recognize that "diverting" a Medicaid recipient to home and community based services does not always mean that the State "saves" the full cost of a nursing facility bed. This is because the bed will still be filled, often by another Medicaid recipient. Approximately 35% of all nursing facility admissions are Medicaid patients.

Therefore, the Department has formulated a hypothetical "cost effectiveness model" that computes the total State costs for providing home care services under the Waiver. This is calculated by adding together the actual cost of services (Waiver services plus skilled nursing, and other home health services), the program's administrative costs, and the Old Age Assistance (OAA) provided to persons receiving home care, which would not be incurred if these persons entered a nursing facility. The program is considered cost-effective if the sum of those three costs is less than the estimate of the savings that the State generates as a result of the reduced utilization of nursing facility beds due to the program. In other words:

SAVINGS	_	COSTS	=	NET SAVINGS
$ 203,579,657	_	**$ 88,304,317**	=	**$ 115,275,340**

This analysis is based on date-of-payment data. It does not include bills that may have been paid after the end of SFY 2006.

The analysis of these factors reveals that the program costs are significantly less than the estimated savings in nursing facility expenditures. The amount of the difference represents the overall savings realized due to the Waiver home care program.

Since an estimate of the savings attributed to the program must be developed on the basis of assumptions about "what would have happened," no such analysis can be considered to be definitive. However, the Department continues to monitor program expenditures and estimated savings and to update its analysis based upon the best information available.

Currently, the State has a moratorium on the construction of nursing facility beds, yet there are vacancies in most facilities. In the face of a growing population of elders, this apparent leveling of nursing home growth is probably the greatest evidence of the success of the CT Home Care Program for Elders in reducing unnecessary institutional expenditures. Many other factors undoubtedly have also influenced this phenomenon.

The Department's formula for estimating the net savings under the Waiver portion of the CT Home Care Program for Elders utilizes an analysis estimating savings by assuming that all Waiver clients would have entered a nursing facility in the absence of the program. In order to be conservative, the first three months stay on the program for new enrollees was not counted toward the savings on the assumption that individuals would try to delay the nursing facility admission as long as possible. Based on the longer length of stay prior to nursing facility admission, the Department has made an additional adjustment in the formula over past years. The Department has not projected savings for any newly enrolled individuals admitted within the fiscal year even though the costs for their services are still counted.

Since new enrollees receive services for an average of six months during the fiscal year of their enrollment, this adjustment has the effect of counting the home care costs but not counting savings for that period. To account for the fact that other Medicaid recipients might fill some of the beds that were left vacant by individuals who enroll in the CT Home Care Program for Elders, the analysis reduces the projected savings by 35% since 35% of nursing home admissions are for individuals on Medicaid.

SFY 2006

Connecticut Home Care Program for Elders

Average (Monthly) Cost / Case
Summary
Based on Date of Payment

Statewide									
Category of Service	**State Funded**			**Title XIX**			**Total**		
	Annual Services	Annual Expenditures	Cost / Service	Annual Services	Annual Expenditures	Cost / Service	Annual Services	Annual Expenditures	Cost / Service
Screening Services									
Assessments	3,073	$ 831,508	$ 271	2,001	$ 538,794	$ 269	5,074	$ 1,370,302	$ 270
Reviews	469	$ 41,461	$ 88	994	$ 88,387	$ 89	1,463	$ 129,849	$ 89
Health Screens	1,179	$ 34,063	$ 29	2,000	$ 57,794	$ 29	3,179	$ 91,857	$ 29
Misc. Adjustments	0	0	0	0	0	0	0	0	0
Sub-Total		$ 907,033			$ 684,976			$ 1,592,008	
	State Funded			Title X1X			Total		
	Average Monthly Clients	Annual Expenditures	Avg. Mo. Cost / Client (a)	Average Monthly Clients	Annual Expenditures	Avg. Mo. Cost / Client (a)	Average Monthly Clients	Annual Expenditures	Avg. Mo. Cost / Client (a)
Waiver Services									
Respite Care	7	$ 33,923	**$ 429**	31	$ 276,508	**$ 753**	37	$ 310,431	$ 696
Non-Medical Transp.	21	$ 24,539	**$ 99**	43	$ 46,612	**$ 90**	64	$ 71,151	$ 93
Case Management	3,527	$ 5,628,333	**$ 133**	8,341	$ 13,981,324	**$ 140**	11,868	$ 19,609,656	$ 138
Adult Day Health	334	$ 3,177,697	**$ 792**	1,006	$ 10,807,628	**$ 895**	1,340	$ 13,985,325	$ 870
Chore	71	$ 153,718	**$ 181**	165	$ 384,299	**$ 194**	236	$ 538,017	$ 190
Companion	729	$ 2,799,509	**$ 320**	2,673	$ 18,110,817	**$ 565**	3,402	$ 20,910,327	$ 512
Elderly Foster Care	1	$ -	**$ -**	0	$ -	**$ -**	1	$ -	$ -
Meals	1,138	$ 2,784,479	**$ 204**	3,032	$ 7,658,079	**$ 210**	4,170	$ 10,442,558	$ 209
Homemaker	2,349	$ 10,512,207	**$ 373**	5,987	$ 39,066,384	**$ 544**	8,336	$ 49,578,591	$ 496
Mental Health Couns.	67	$ 121,995	**$ 152**	225	$ 424,633	**$ 158**	291	$ 546,627	$ 156
Personal Emerg. Resp.	1,818	$ 1,232,412	**$ 56**	4,821	$ 3,373,427	**$ 58**	6,639	$ 4,605,839	$ 58
Assisted Living	159	$ 2,757,553	**$ 1,441**	113	$ 2,039,157	**$ 1,503**	273	$ 4,796,710	$ 1,467
Sub - Total	4,933	$ 29,226,365	$ 494	10,305	$ 96,168,867	$ 778	13,221	$ 125,395,232	$ 790
Home Health Svcs. (b)	4,933	$ 9,194,695	$ 155	10,305	$ 63,697,935	$ 515	13,221	$ 72,892,630	$ 459
Total - Comm. Svcs.	4,933	$ 39,328,092	$ 664	10,305	$ 160,551,778	$ 1,298	15,238	$ 199,879,870	$ 1,093

(a) Average Monthly Cost per Client reflects the Average Monthly Expenditures divided by the Average Monthly Participating Clients.
(b) Home Health Expenditures for Title XIX Clients are Estimated

SUMMARY OF PROGRAM COSTS AND SAVINGS (BY DATE OF PAYMENT)
WAIVER CLIENTS
SFY 2006

	ASSESSMENTS	
A	Assessments	2,001
B	Cost/Assessment	$269
C	Annual Assessment Cost (AxB)	$538,794
	COMMUNITY & HOME HEALTH SERVICES	
	Average Monthly Clients Served	10,305
	Monthly Community Services Cost	$778
D	Annual Community Services Cost	$96,168,867
	Monthly Home Health Cost	$515
E	Annual Home Health Cost	$63,697,935
	Annual Status Reviews	994
F	Annual Status Review Cost	$88,387
G	Annual Services Cost (D+E+F)	$159,955,189
	AID TO THE AGED, BLIND, & DISABLED	
	Average Monthly Clients Served	2,473
	Monthly OAA Cost	$509
H	Annual OAA Cost	$15,106,306
	ADMINISTRATIVE EXPENSES	
	Personal Services	$653,120
	Fringe Benefits	$355,225
	Other Expenses	$0
I	Annual Administrative Cost*	$1,008,345
J	Total Program Costs for SFY 2006 (C+G+H+I)	$176,608,634
K	Adjustments	$0
L	Adjusted Total Program Costs for SFY 2006 (J+K)	$176,608,634
M	Federal Medicaid Reimbursement (50%xL)	($88,304,317)
N	Total State Program Costs After Federal Reimbursement (L+M)	$88,304,317
	NURSING HOME SAVINGS	
O	Average Monthly Continuing Clients	10,135
P	Monthly NH Cost per Medicaid Client	$5,150
Q	Nursing Home Savings Due to CHCP: Total Client Months for Continuing Clients (Ox12)	121,620
R	Annual Nursing Home Savings Due to CHCP (PxQ)	$626,398,945
S	Additional Costs for Medicaid Nursing Home Beds Filled Due to Diverted CHCP Clients (35%xR)	($219,239,631)
T	Total Nursing Home Savings for SFY 2006 (R+S)	$407,159,314
U	Federal Medicaid Reimbursement (50%xT)	($203,579,657)
V	Total Nursing Home Savings After Federal Reimbursement (T+U)	$203,579,657
	NET FISCAL IMPACT	
	Net State Savings for SFY 2006 (V-N)	$115,275,340

*Health Screens not included

SFY 2006
CONNECTICUT HOME CARE PROGRAM FOR ELDERS
PROGRAM COSTS BY DATE OF PAYMENT

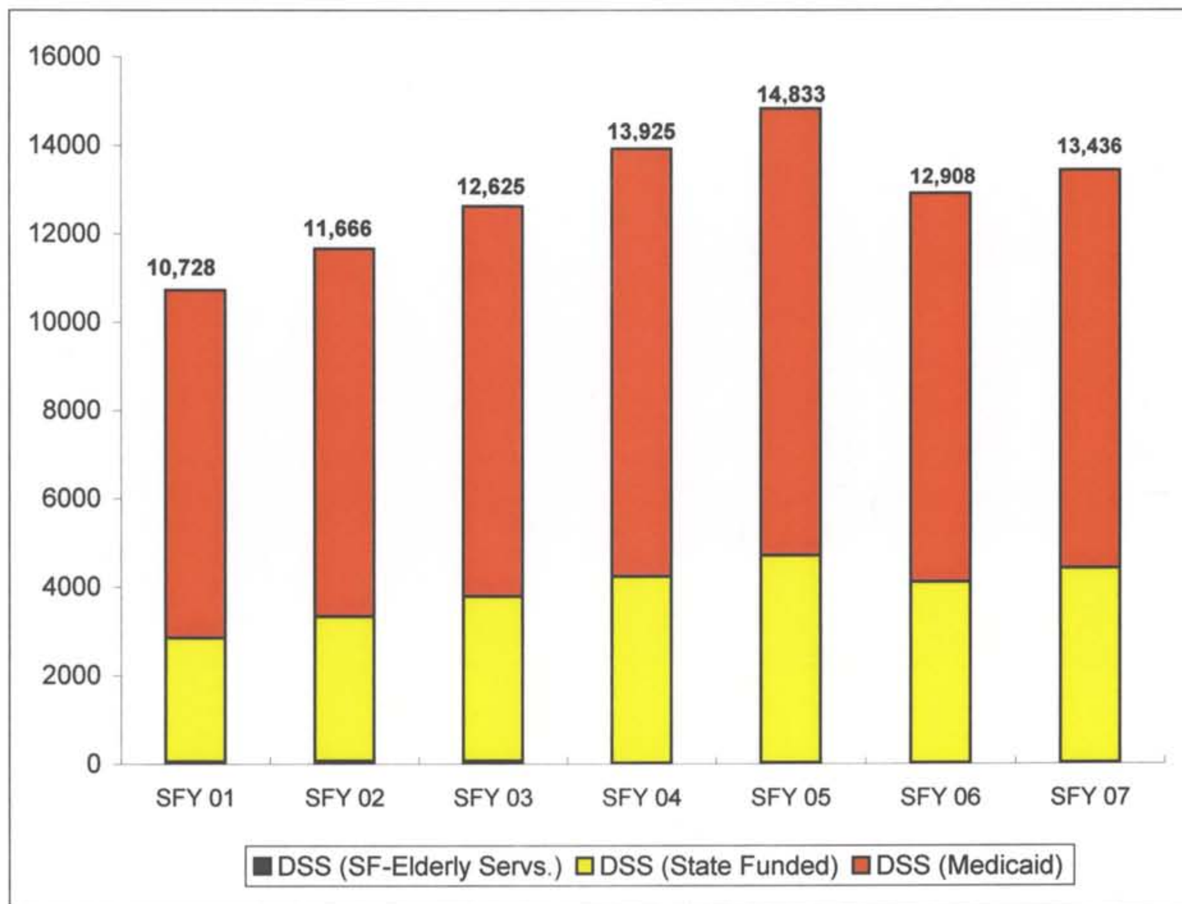
	State Funded	Waiver	Total
Program Expenses			
Assessments / Status Reviews	$ 907,033	$ 684,976	$ 1,592,008
Home and Community Based Services	$ 38,421,060	$ 159,866,802	$ 198,287,862
Sub - Total Expenses	$ 39,328,092	$ 160,551,778	$ 199,879,870
State-Funded PCA Pilot (Allied Community Resources)	$1,945,319	-	$1,945,319
Adjustments	$ (349,849)	$ -	$ (349,849)
Administrative Services			
Personal Services	$ 301,071	$ 653,120	$ 954,191
Fringe Benefits	$ 163,790	$ 355,225	$ 519,016
Other Expenses (Rent costs for allocated staff)	$ -	$ -	$ -
Annual Administrative Costs	$ 464,861	$ 1,008,345	$ 1,473,207
Net Costs			
Total Cost	$ 41,388,424	$ 161,560,123	$ 201,003,228
SSBG Funding - Program	$ -	$ -	$ -
SSBG Funding - Administrative	$ -	$ -	$ -
Federal Reimbursement - Medicaid *	$ -	$ (80,780,061)	$ (80,780,061)
Net State Costs for SFY 2006	$ 41,388,424	$ 80,780,061	$ 120,223,167

*Estimated at 50% federal financial participation

The following chart illustrates the overall trend in home care growth for elders within Connecticut.

ELDER HOME CARE CLIENTS
AVERAGE MONTHLY CASELOADS

	DSS State Funded (Elderly Services)	*DSS State Funded*	*DSS Medicaid (Waiver)*	*TOTAL*
SFY 01	*51*	*2,794*	*7,883*	*10,728*
SFY 02	*67*	*3,260*	*8,339*	*11,666*
SFY 03	*65*	*3,714*	*8,846*	*12,625*
SFY 04	*16*	*4,223*	*9,686*	*13,925*
SFY 05	*19*	*4,690*	*10,124*	*14,833*
SFY 06	*13*	*4,090*	*8,805*	*12,908*
SFY 07	*22*	*4,393*	*9,021*	*13,436*



CONNECTICUT HOME CARE PROGRAM OVERVIEW

Financial Eligibility – Medicaid Waiver

In order to qualify financially for the Waiver portion of the program, an elderly person (age 65 or older) must meet the income and asset rules applicable to an institutionalized Medicaid applicant. As specified in the Federal Waiver, this means that the gross income limit is 300% of the SSI payment, or $1,809. The asset limit for an unmarried applicant is $1,600, although a number of resources such as a residence, car, burial reserve and $1,500 face value life insurance policy are exempt. There are special provisions in federal law regarding the treatment of assets for married couples when one spouse is considered "institutionalized" which allows for the protection of assets for the community spouse. As of January 2006, the law allowed a community spouse to protect assets from $19,908 up to $99,540 depending upon the couple's original assets, in addition to the $1,600 that the "institutionalized" person can keep. If both spouses require Waiver services, each can only have assets of $1,600 after exemptions.

Financial Eligibility – State Funded

The State Funded portion of the program has no income limit. The financial eligibility difference between State Funded and Medicaid Waiver is related to asset limits. When the State Funded programs were consolidated in 1992, an asset limit was established to enable individuals with more assets than the Medicaid limit, but not unlimited assets, to qualify for State Funded home care. However, existing clients with assets higher than the new limit were allowed to continue receiving services. The asset limit for an individual in the State Funded portion of the program is equal to the minimum amount that a community spouse could have under Medicaid; this figure was $19,908 as of January 2006. A couple on the State Funded portion of the program can have 150% of that amount, or $29,862 as of January 2006.

Targeting the Frail Older Person

A uniform health screen is completed with those financially eligible persons applying to the program. The screen collects information about the person's ability to perform basic activities of daily living and to carry out more complex tasks like preparing meals and managing medications. The screen also provides a profile of the person's cognitive status, behavior problems, if any, and informal support system. When the Department's clinical staff determines need for the program, appropriate clients may be referred to an access agency care manager for an assessment of their service needs. The screen is also used to establish the need for nursing facility care for elders who are seeking direct nursing facility admission.

From July 1, 2005 through June 30, 2006, the Alternate Care Unit screened 14,875 elderly persons in contrast to 14,785 the previous year. This represents an increase of .6%. In SFY06, 6,605 individuals, approximately 44% of those screened, were referred for a full assessment of their needs to consider their potential for community placement. This is an increase of 7.1% over the previous year of 6,170.

Client Targeting

	Persons Screened	Referred for Assessment	New Clients
SFY 2005	14,785	6,170 41.7%	4,361 29.5%
SFY 2006	14,875	6,605 44.4%	4,192 28.2%

Note: Percentages are based on the number of persons screened

Assessment, Plan of Care Development, and Care Management

The care manager conducts a full assessment of the individual's service needs. Based on the results of the assessment, the care manager develops a written, individualized plan of community based social and medical services. The comprehensive plan of care specifies the type, frequency, and cost of all services required for each client. The care manager is required to use the client's informal support system and pursue other funding sources before relying upon program funds. Direct client services other than care management are rendered by agencies which subcontract with the Access Agency and are registered with the Department.

Many individuals receiving home care services also receive the services of an independent care manager throughout their stay on the program. The care manager is a nurse or social worker who monitors the client's status monthly, reviews the care plan regularly and fully reassesses the client annually. Care management also includes ensuring that services are provided in accordance with the plan of care. As noted, care management is only provided when needed by the individual.

Application of Cost Limits

Once the plan of care is completed, the care manager must assure that the State's cost for the client's total plan of care, both medical and community based social services, does not exceed the average State cost of nursing facility care. This amount is calculated by deducting the average applied income contribution from the weighted average monthly Medicaid rate for nursing facility beds.

As of July 1, 2005, the limit on the total plan of care was $5,150.46; there was no increase in the cost limit in January 2006. As noted above, the cost limits on the State Funded portion of the program are based on a percentage of this amount. There is also a specific requirement that the cost of social services under the Waiver cannot exceed 60% of the average nursing home rate. As of July 1, 2005, the limit on total plan of care for Medicaid Waiver Social Services costs was $3,665.00 and remained the same through the end of SFY 2006.

Client Fee

Individuals who qualify for services under the special institutional income limit used for the Waiver and the State Funded component have a portion of their income applied to the cost of their care if their income exceeds 200% of the Federal Poverty Level plus the cost of any medical insurance premiums paid and other allowable deductions from the individual's gross income. Any remaining income must be paid toward the cost of care.

Acceptance of Services

The elderly individual is offered the choice of accepting a plan of home and community based care as an alternative to institutional care. This choice is required by federal law and must be documented in writing. In SFY 2006, 4,192 clients accepted plans of care for home and community based services in contrast to 4,361 in the prior year. This represents 63% of the persons referred for assessment.

Length of Stay on the CT Home Care Program for Elders

Analysis of the data on all persons placed on services since SFY 1988, who have been discharged as of June 2006, indicates an average length of stay of 3.3 years.

Client Characteristics

The majority of the CT Home Care Program for Elders participants are Caucasian, female, widowed, live alone and are between the ages of 70 and 94. The following 3 pages present tables and additional demographic and social information of clients served by the CT Home Care Program for Elders.

CLIENT CHARACTERISTICS
SFY 2006

DEMOGRAPHIC AND SOCIAL INFORMATION

AGE	
UNDER 65*	0.0%
65-69	8.5%
70-74	15.1%
75-79	19.2%
80-84	21.5%
85-89	19.7%
90-94	11.7%
95-99	3.7%
OVER 99	0.6%

MARITAL STATUS	
WIDOWED	56.0%
MARRIED	18.6%
DIVORCED	13.7%
SEPARATED	2.9%
NEVER MARRIED	8.7%

RACE/ETHNICITY	
CAUCASIAN	71.7%
BLACK	13.6%
HISPANIC	12.7%
AM. INDIAN/ALASKAN NATIVE	0.1%
ASIAN/PACIFIC ISLANDER	0.7%

GENDER	
FEMALE	75.3%
MALE	24.7%

LIVING ARRANGEMENT	
ALONE	54.9%
WITH SPOUSE	14.9%
W/CHILDREN	21.2%
W/SPOUSE/CHILD.	2.1%
W/SIBLING/RELATIVES	3.7%
W/NON-RELATIVES	3.4%

HOUSING	
ELDERLY/OTHER SUBSIDIZED	41.7%
HOME OF CHILD/OTHER REL.	21.0%
APARTMENT/TRAILER	20.2%
OWN HOUSE/CONDO	11.0%
NURSING HOME/OTHER INSTIT.	2.2%
OTHER	3.9%

MEDICAID	
YES	71.5%
NO	28.5%

* Clients who are under the age of 65 and receiving CBS were grandparented in on the program from a pilot preadmission screening program.

CLIENT CHARACTERISTICS
SFY 2006

HEALTH STATUS

SELF-PERCEIVED HEALTH	
GOOD	33.2%
FAIR	54.6%
POOR	11.3%
INFO INCOMPLETE	0.9%

ACTIVE MEDICAL PROBLEMS	
HEART DISEASE	31.9%
CVA/STROKE	13.7%
CANCER	12.2%
RESPIRATORY	12.9%
DIABETES	34.0%
ALZH/OTHER DEMENTIA	21.3%

MUSCULOSKELETAL	
ARTHRITIS	62.5%
FRACTURES	8.8%
OSTEOPOROSIS	15.7%

CLIENT CHARACTERISTICS
SFY 2006

PHYSICAL FUNCTION

IADL DEPENDENCIES*	
SHOPPING	96.3%
TRAVEL/TRANSPORTATION	89.3%
HOUSEKEEPING	97.8%
LAUNDRY	92.2%
MEAL PREP	94.1%
MANAGING MEDICATIONS	76.7%
MANAGING FINANCES	73.1%
TELEPHONING	19.1%

ADL DEPENDENCIES***	
BATHING	83.3%
DRESSING	52.3%
TOILETING	14.6%
TRANSFERRING	15.8%
BLADDER CONTINENCE	26.1%
BOWEL CONTINENCE	12.9%
FEEDING(EATING)	12.4%

MOBILITY DEPENDENCY	
STAIRCLIMBING	62.2%
MOBILITY(OUTDOORS)	42.2%
WALKING(INDOORS)	20.8%
WHEELING	22.5%

INDICATORS OF COGNITIVE FUNCTION

COGNITIVE IMPAIRMENT (SCORES ON MSQ**)	
NONE OR MINIM. IMPAIRMENT(0-2 errors)	79.5%
MODERATE IMPAIRMENT(3-8 errors)	17.1%
SEVERE IMPAIRMENT(9-10 errors)	3.4%

BEHAVIOR PATTERN	
WANDERING	2.1%
OTHER	2.2%
ABUSIVE	2.3%
UNSAFE	6.1%
REQUIRES SUPERVISION	19.7%

* Instrumental Activities of Daily Living

** Mental Status Quotient

*** Activities of Daily Living

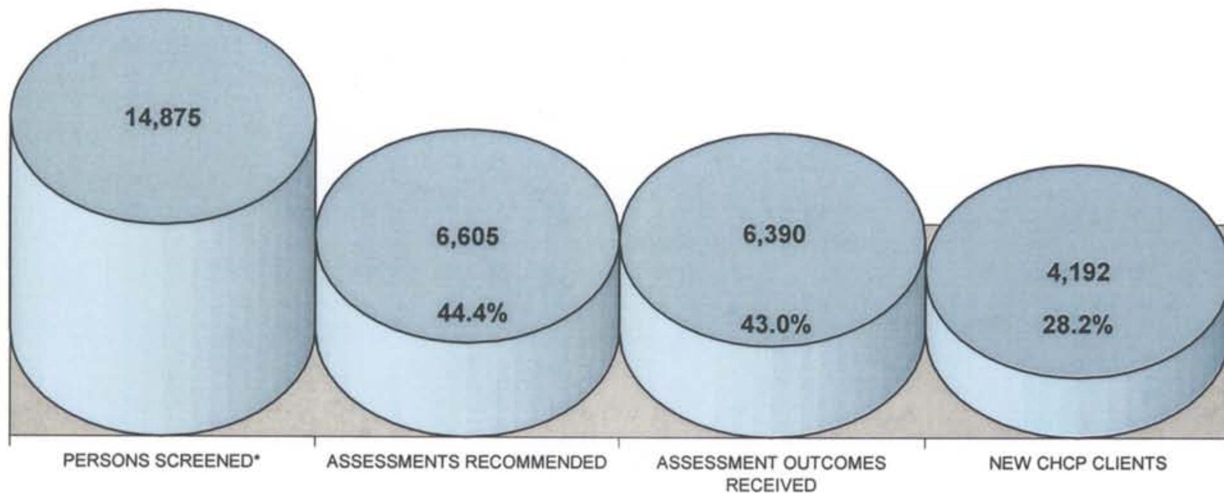
CASELOAD TRENDS
7/1/05 - 6/30/06

During the nineteenth year of operations, July 1, 2005 through June 30, 2006, the combined Waiver and State Funded Program caseload increased by 4.6%.

Screening, Assessment and Placement Activity

The number of new clients placed on services during SFY 2006 was 4,192. An average of 349 new clients were placed on services each month and an average of 266 discharges occurred, resulting in an average net increase of 83 clients each month.

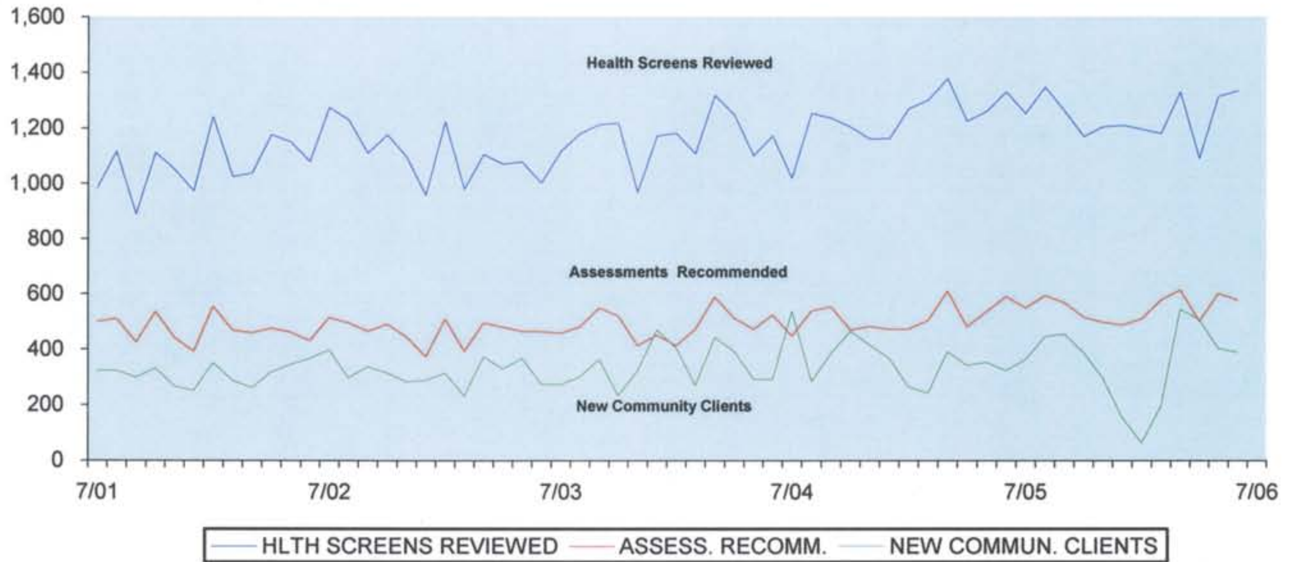
SFY06 PROGRAM ACTIVITY



*Includes people screened for OBRA and direct nursing home admissions

Composite of Program Activity

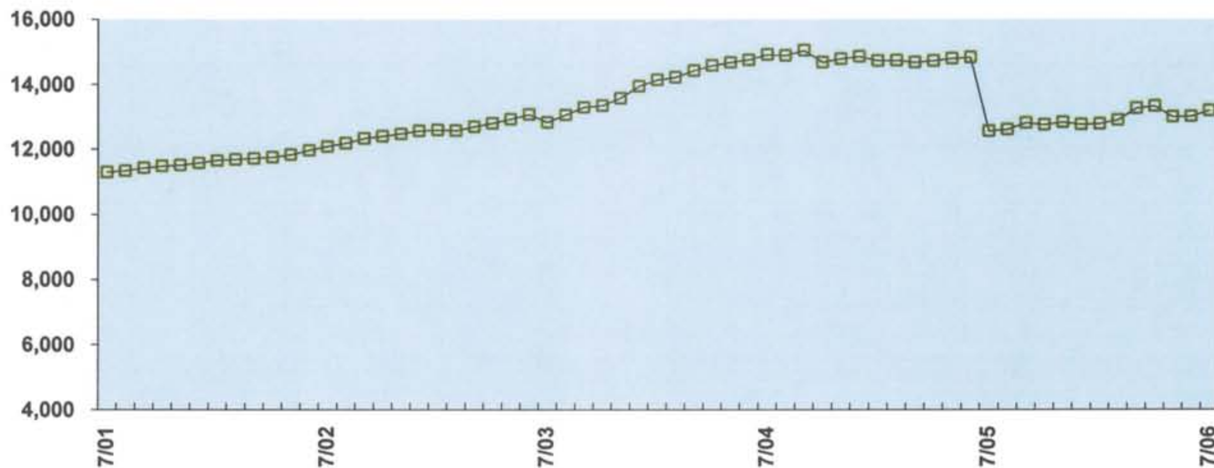
The composite of program activity graph reflects the pattern of processing that has occurred since July 2001.



Caseload

The following graph illustrates the Connecticut Home Care Program for Elders caseload since July 2001. As of June 30, 2006, there were 13,027 clients. This represents a 4.6% increase from the 12,454 active cases at the end of SFY 2005. The monthly average Connecticut Home Care Program for Elders caseload for SFY 2006 was 12,895.

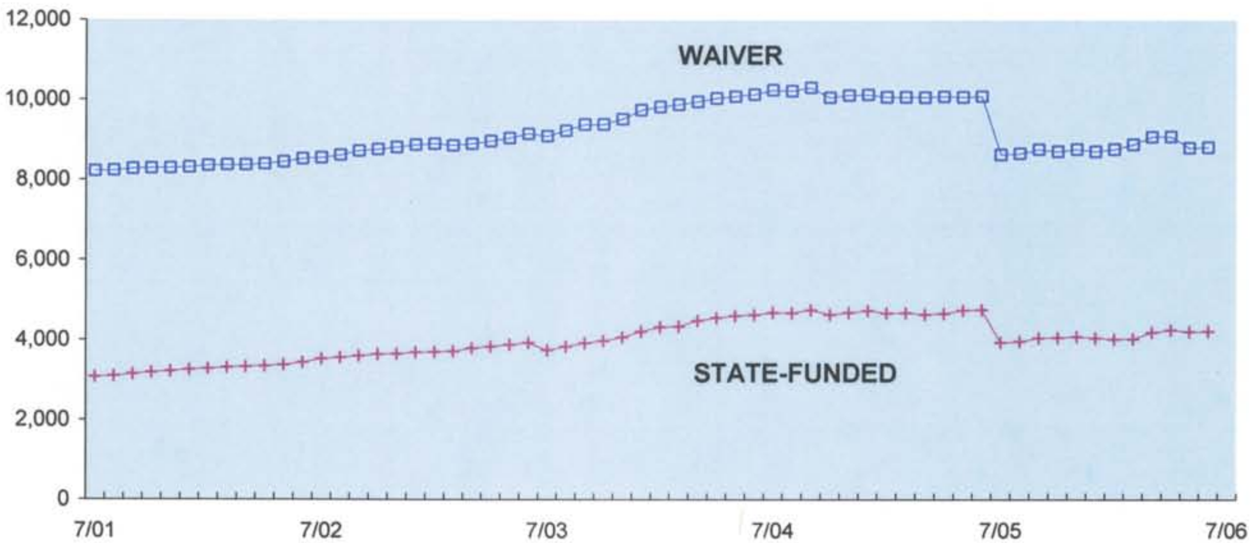
CONNECTICUT HOME CARE PROGRAM CASELOAD GROWTH



Caseload by Funding Source

As of July 1, 1989, all State Funded clients were required to apply for Medicaid if their financial information indicated that they would qualify.

The graph below illustrates the volume trends for State Funded and Waiver clients since the beginning of SFY 2002. As of June 30, 2006, approximately 68% of the persons receiving program services were Waiver clients.



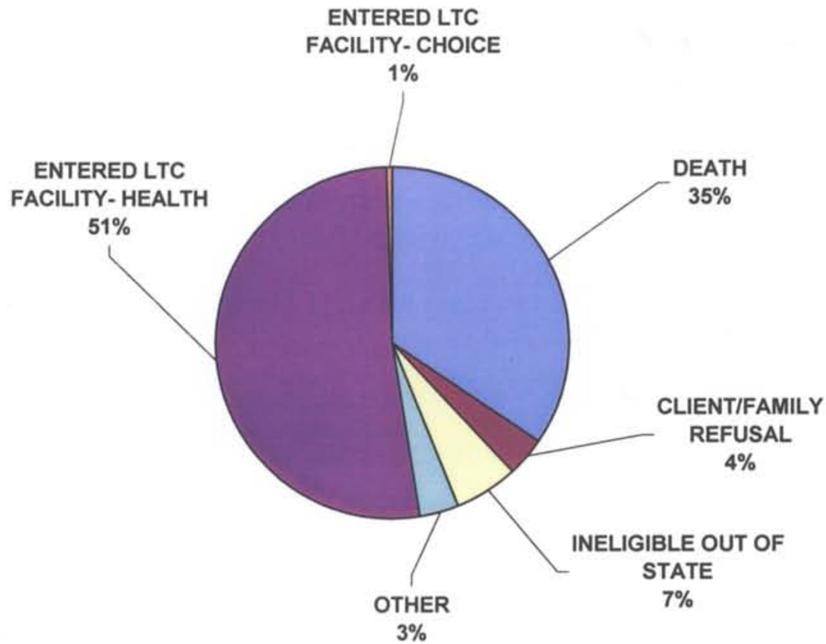
Admissions and Discharges

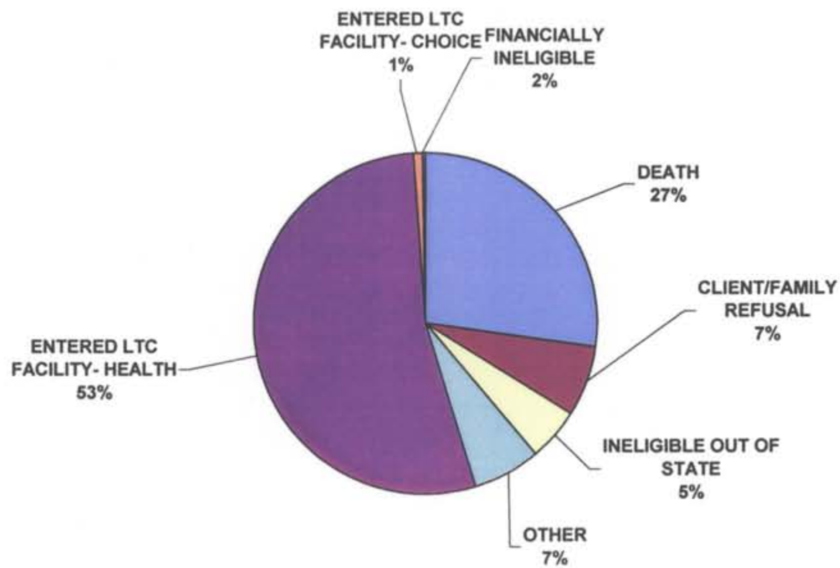
Since July of 1990 the Department has monitored the volume of Waiver and State Funded clients.

CT HOME CARE PROGRAM FOR ELDERS PROGRAM ACTIVITY

SFY 2006

	Waiver Clients (Level 3)	Funded State Clients (Level 2)	State Funded Clients (Level 1)	Total
Beginning Clients	8,568	2,242	1,644	12,454
Adjustments	(38)	(135)	(235)	(408)
Admissions	2,042	1,181	969	4,192
Discharges	(2,209)	(801)	(201)	(3,211)
Category Changes	449	(135)	(314)	0
Ending Clients	8,812	2,352	1,863	13,027


SFY 2006 WAIVER DISCHARGE REASONS
ENTERED LTC FACILITY- CHOICE 1%
DEATH 35%
CLIENT/FAMILY REFUSAL 4%
INELIGIBLE OUT OF STATE 7%
OTHER 3%
ENTERED LTC FACILITY- HEALTH 51%


SFY 2006 STATE-FUNDED DISCHARGE REASONS
ENTERED LTC FACILITY- CHOICE 1%
FINANCIALLY INELIGIBLE 2%
DEATH 27%
CLIENT/FAMILY REFUSAL 7%
INELIGIBLE OUT OF STATE 5%
OTHER 7%
ENTERED LTC FACILITY- HEALTH 53%

Transfers Within the Program

Since all home care services are now consolidated under the Department of Social Services, individuals do not need to transfer from one Department to another as their needs change. Most older persons who receive home care services from the Department are served under the Connecticut Home Care Program for Elders. However, some individuals who were "grandparented" into the former Essential Services Program, now the Department's Adult Services Division Community Based Services Program, continue to receive services through the Connecticut Home Care Program for Elders. These individuals do not necessarily qualify for the Medicaid Waiver; however, once qualified, these individuals are generally transferred to Medicaid to capture federal matching funds for their services.

Individuals within the program, who experience a change in functional or financial status may also qualify for a change in their category of services designation. This change enables them to access increases in the care plan cost limits. Those who qualify for Category 3 gain access to full Medicaid benefits. The change to Category 3 enables the Department to maximize federal financial participation under Medicaid.

These changes have been made virtually seamless for the client. The following chart on category changes demonstrates the intra-program transfers that enable elders to increase services and enable the State to increase federal revenues as functional needs increase.

SFY 2006 CATEGORY CHANGES

FROM:	TO:	TOTAL TRANSFERS
CAT. 1	CAT. 2	80
CAT. 1	CAT. 3	234
TOTAL CAT. 1 TRANSFERS		314
CAT. 2	CAT. 3	258
CAT. 3	CAT. 2	43

PROGRAM EXPENDITURES AND COST SAVING PROGRAM ACTIVITIES

Program Expenditures 7/1/05 - 6/30/06

Actual program expenditures in SFY 2006 totaled $198,287,862 before federal reimbursement. Actual expenditures after federal funds and reimbursement were $118,354,461.

SFY 2006 Expenditures

	Waiver	State Funded	Total
Average Monthly Cost/Case	$ 1,298	$ 664	$ 1,093
Total Cost	$ 159,866,802	$ 38,421,060	$ 198,287,862
Federal Funds/ Reimbursement	($ 79,933,401)	($ -0-)	($ 79,933,401)
Net State Cost	$ 79,933,401	$ 38,421,060	$ 118,354,461

Mandatory Medicaid Applications

As noted above, all State Funded clients served by the Department are required to apply for Medicaid if their financial information indicates that they would qualify. This insures that the State receives the 50% match of federal funds wherever possible and lowers the percentage of clients whose services are purchased with 100% State funds. State Funded clients who appear to be eligible for Medicaid continue to be identified when their income and assets are reviewed during annual reassessments of functional status.

For information regarding this report, please call:
Department of Social Services, Alternate Care Unit at
1-800-445-5394

APPENDIX A -1

Brief History of the Connecticut Home Care Program for Elders

In the mid 1980's, the federal government offered states opportunities for expanding home care under special options called Medicaid "home and community-based services waivers." These options were called waivers because they allowed states to "waive" certain Medicaid rules including restrictive income limits and prohibitions against coverage for non-medical services. The rationale for creating the federal waivers rested in the belief that individuals, who would otherwise be institutionalized at the state's expense, could be diverted from this costly option if services were available to support them at home. In addition to home health services already covered by Medicaid (e.g. nursing, home health aide, physical therapy, speech therapy, occupational therapy and medical transportation), a wide array of home care services were considered necessary to adequately support a frail elder in the community. These services included: homemaker, home delivered meals, adult day care, chore help, non-medical transportation, companionship, emergency response systems, respite care, mental health counseling and care management. The federal waiver option thus allowed states to receive federal matching funds (50% match in Connecticut) for services which previously had been paid primarily with state funds.

In 1985, following a successful demonstration project, the Connecticut General Assembly voted to establish an expanded home care program taking advantage of the new waiver option. This legislation directed the Department of Income Maintenance (DIM) to apply for the federal waiver to maximize federal reimbursement but also required the program to serve individuals who would not qualify for the waiver and whose services would thus be fully state-funded. The program, then called the Long Term Care Pre-Admission Screening and Community-Based Services Program, (PAS/CBS) began statewide operation in 1987. It was targeted to very frail elders identified by hospital or nursing facility staff as likely to be admitted to a nursing facility within sixty days.

In 1990, the General Assembly began steps to consolidate home care services for elders. Public Act 90-182 ended admissions for elders in the Adult Services Program operated by the Department of Human Resources and in the state-funded portion of the PAS/CBS program operated by DIM. While existing clients were able to continue receiving services through their respective programs, new applicants in need of state-funded home care services were referred to the Promotion for Independent Living at the Department on Aging. Elders who were eligible for the Medicaid Waiver program could still apply to the Department of Income Maintenance.

The second phase of the consolidation came at the end of the SFY'92 Session. Through Public Act 92-16 of the May Session, the General Assembly merged three major programs: The Pre-admission Screening and Community Based Services, The Promotion of Independent Living and The Elder Services portion of the Adult Services Program and reinstated the state-funded portion of the home care program. The home care program was then renamed The Connecticut Home Care Program for Elders.

Under the umbrella of the Connecticut Home Care Program for Elders, the program continued to have two components, one fully state-funded; the other receiving matching funds under the federal waiver. The following year, the State reorganized several human services departments resulting in the consolidation of the three original departments under the new Department of Social Services.

Over the past years, new developments in the program increased consumer choices and expanded opportunities for consumers to influence the services that so directly affected their lives.

In February 1993, recognizing that many frail older persons were capable of working directly with their providers to assure that their service needs were met safely and efficiently, the Department began to implement a concept called "self directed care."

APPENDIX A -2

In SFY '95 with the enactment of P.A. 95-160 Subsection 7 of this act eliminated the licensing of Co-coordination, Assessment and Monitoring Agencies and substituted in their place a new entity called an "Access Agency." The Department consulted with the Home Care Advisory Committee over the following summer to develop standards for this new agency and issued regulations and a Request for Proposals the following November. New Department contracts to provide assessment and care management services were awarded in 1996 to three area Access Agencies.

The establishment of a waiting list for the Connecticut Home Care Program for Elders, in effect from SFY '96 through SFY'97, slowed the growth of the program. Intake for the home care program re-opened in August 1996, and by December 1997 all eligible individuals applications from that waiting list were processed for program services.

The Home Care Program for Elders has continued to evolve over the years to better meet the needs of Connecticut's older citizens. The program uses state-of-the-art approaches in delivering home care services to frail elders who are at risk of institutionalization. The program structure is ever evolving to accommodate changes at both the federal and state level.

APPENDIX B

DEPARTMENT OF SOCIAL SERVICES
CONNECTICUT HOME CARE PROGRAM FOR ELDERS - FEE FOR SERVICE USE ONLY
Effective January 1, 2006

Category Type	Description	Functional Need	Financial Eligibility	Care Plan Limits	Funding Source	Intake Status
Category 1	Limited home care for moderately frail elders	At risk of hospitalization or short term nursing home placement (1 or 2 critical needs)	Individual Income= No Limit* Assets: Individual = $ 19,908.00 Couple= $ 29,862.00	<25% NH Cost ($1,287.00 Monthly)	STATE	OPEN
Category 2	Intermediate home care for very frail elders with some assets above the Medicaid limits.	In need of short or long term nursing home care (3 critical needs)	Individual Income= No Limit* Assets: Individual = $ 19,908.00 Couple= $ 29,862.00	<50% NH cost ($2,575.00 Monthly)	STATE	OPEN
Category 3	Extensive home care for very frail elders who would other-wise be in a nursing home on Medicaid.	In need of long term nursing home care (3 critical needs)	Individual Income=$1,809.00/Mth* Assets: Individual = $1,600.00 Couple: (both as clients) = $3,200 (one as client) = $21,508.00**	100% NH Cost ($5,150.46 Monthly) (Social Services Cap=$3,665.00)	MEDICAID WAIVER	OPEN

Notes:

1. Clients in the higher income range are required to contribute to the cost of their care.
* 2. There is no income limit for the State Funded portion. The Medicaid Waiver income limit remains at 300% of SSI.
3. Services available at all categories include the full range of home health and community based services.
4. Care plan limits at all categories are based on the total cost of all state-administered services.
5. Some individuals may be eligible for category 1 services but be financially eligible for Medicaid.
   In these cases, they will have their home health services covered by Medicaid with other community based services covered by state funds.
6. Some indivduals under category 2 may become financially eligible for the Medicaid Waiver;
   In these cases, the client must apply for Medicaid and cooperate with the application process.
** 7. Married couples who are over this asset limit for category 3 may be eligible based on the special spousal asset protection rule.
8. Functional need is a clinical determination by the Department about the applicant's critical need for assistance in the following areas:
   Bathing, Dressing, Toileting, Transferring, Eating/Feeding, Meal Preparation and Medication Administration.
9. Care Plan limits are for CHCP fee for service only
10. For contracted Access Agencies use only.

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APPENDIX C-1

Sec. 17b-342. (Formerly Sec. 17-314b). Connecticut home-care program for the elderly.

(a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility which has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The annualized cost of the community-based services provided to such persons under the program shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities. The program shall be structured so that the net cost to the state for long-term facility care in combination with the community-based services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or food stamps program. Only a United States citizen or a non-citizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has mental retardation shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

(b) The commissioner shall solicit bids through a competitive process and shall contract with an access agency, approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection (e) of this section, that submits proposals which meet or exceed the minimum bid requirements. In addition to such

contracts, the commissioner may use department staff to provide screening, coordination, assessment and monitoring functions for the program.

(c) The community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Recipients of state-funded services and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

(d) Physicians, hospitals, long-term care facilities and other licensed health care facilities may disclose, and, as a condition of eligibility for the program, elderly persons, their guardians, and relatives shall disclose, upon request from the Department of Social Services, such financial, social and medical information as may be necessary to enable the department or any agency administering the program on behalf of the department to provide services under the program. Long-term care facilities shall supply the Department of Social Services with the names and addresses of all applicants for admission. Any information provided pursuant to this subsection shall be confidential and shall not be disclosed by the department or administering agency.

(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to define "access agency", to implement and administer the program, to establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process and to specify conditions of eligibility.

(f) The commissioner may require long-term care facilities to inform applicants for admission of the program established under this section and to distribute such forms as the commissioner prescribes for the program. Such forms shall be supplied by and be returnable to the department.

(g) The commissioner shall report annually, by June first, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the program in such detail, depth and scope as said committee requires to evaluate the effect of the program on the state and program participants. Such report shall include information on (1) the number of persons diverted from placement in a long-term care facility as a result of the program, (2) the number of persons screened, (3) the average cost per person in the program, (4) the administration costs, (5) the estimated

savings, and (6) a comparison between costs under the different contracts.

(h) An individual who is otherwise eligible for services pursuant to this section shall, as a condition of participation in the program, apply for medical assistance benefits pursuant to section 17b-260 when requested to do so by the department and shall accept such benefits if determined eligible.

(i) (1) On and after July 1, 1992, the Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the program for persons (A) who are sixty-five years of age and older; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed under subdivision (3) of subsection (a) of this section; and (D) whose assets, if single, do not exceed the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount and on and after April 1, 2007, whose assets, if single, do not exceed one hundred fifty per cent of the minimum community spouse protected amount pursuant to Section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount.

(2) Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute to the cost of care in accordance with the methodology established for recipients of medical assistance pursuant to Sections 5035.20 and 5035.25 of the department's uniform policy manual.

(3) On and after June 30, 1992, the program shall serve persons receiving state-funded home and community-based services from the department, persons receiving services under the promotion of independent living for the elderly program operated by the Department of Social Services, regardless of age, and persons receiving services on June 19, 1992, under the home care demonstration project operated by the Department of Social Services. Such persons receiving state-funded services whose income and assets exceed the limits established pursuant to subdivision (1) of this subsection may continue to participate in the program, but shall be required to pay the total cost of care, including case management costs.

(4) Services shall not be increased for persons who received services under the promotion of independent living for the elderly program over the limits in effect under said program in the fiscal year ending June 30, 1992, unless a person's needs increase and the person is eligible for Medicaid.

(5) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such amount under the Department of Social Services in the fiscal year ending

APPENDIX C-4

June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

(j) The Commissioner of Social Services may implement revised criteria for the operation of the program while in the process of adopting such criteria in regulation form, provided the commissioner prints notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing the policy. Such criteria shall be valid until the time final regulations are effective.

APPENDIX D

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APPENDIX E

(Rev. 8/07)

CARE MANAGEMENT CONTINUUM

Maximum Self Direction → Minimum Self Direction

Client Managed	Client Coordinated	Provider Coordinated	Provider Managed	Access Agency Coordinated	Access Agency Managed
Client or Family hires and trains workers independently or through a broker. (Personal Care Assistance Model available under CHCPE as a Pilot Program)	Client/Family purchases services through social service agencies and occasionally health agencies and is able to maintain maximum control of decision making. Scheduling and monitoring (third party may pay for the services purchased.)	Client/Family receives services primarily through a health agencies; one agency takes the primary role in coordinating and monitoring health services, and possibly referring to other services, but the client/family assume responsibility for co-ordinating and monitoring the total plan of care	Client/Family receives services primarily through a lead health agency which subcontracts with other agencies, as needed, to provide support services. The lead health agency assumes full responsibility for coordination and monitoring of plan of care with client/family input. (Lead Provider)	Client/Family receives services which are arranged, coodianted and monitored by an access agency. Client is able to retain a high degree of control over decision making, scheduling and monitoring; therefore, care management by an a access agency may not be intensive and may be short term	Client/Family receives services which are arranged, coordianted and monitored by an access agency. Due to cognitive status of client and/or lack of family support, client control is limited and care management by an access agency is intensive

APPENDIX F-1

CT Home Care Program For Elders
North Western Region
Client Satisfaction Survey Report
May 2006

I. SURVEY ADMINISTRATION AND POPULATION

The Alternate Care Unit conducted a client satisfaction survey for Connecticut Home Care Program for Elders (CHCPE) care managed clients residing in the program's North Western Region. A cover letter (Appendix I) and a two-page survey (Appendix II) were sent to three hundred and seventy (370) active CHCPE clients. This represents twelve percent (12%) of the total client population residing in the program's North Western Region.

The surveys were mailed on May 12, 2006. Clients were asked to return the survey by June2, 2006. Survey participants were selected randomly by computer from DSS active client files. Two hundred sixty-one (261) Medicaid Waiver clients were sent surveys. They represented seventy-one percent (71%) of the selected survey population. One hundred nine (109) surveys or twenty-nine percent (29%) of all surveys sent were to state-funded clients. The surveyed population is a representative sample of program participants in the program's North Western Region. Survey administration and population specifics can be found in Appendix III.

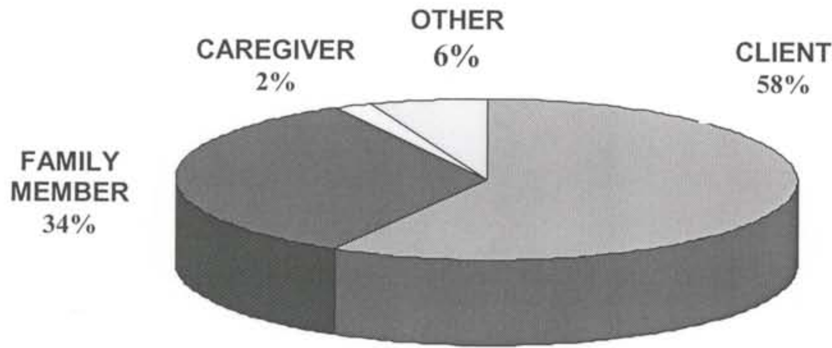
II. SURVEY RESULTS

Thirty-seven percent (37%) of surveyed clients responded to the survey. Seventeen percent (17%) of all surveys mailed were returned undelivered because of incorrect address, insufficient address, etc. The survey's response rate rises to forty-four percent (44%) when undelivered surveys are deducted from the total number of surveys mailed. A breakdown of the reasons surveys were not delivered can be found in Appendix IV.

The survey results are presented in eight (8) defining categories: (1) respondent identifier; (2) CHCPE alternatives; (3) service satisfaction; (4) service dependability; (5) contact awareness; (6) success with meeting client's home care needs; (7) care management awareness; and (8) service utilization.

A. Respondent Identifier

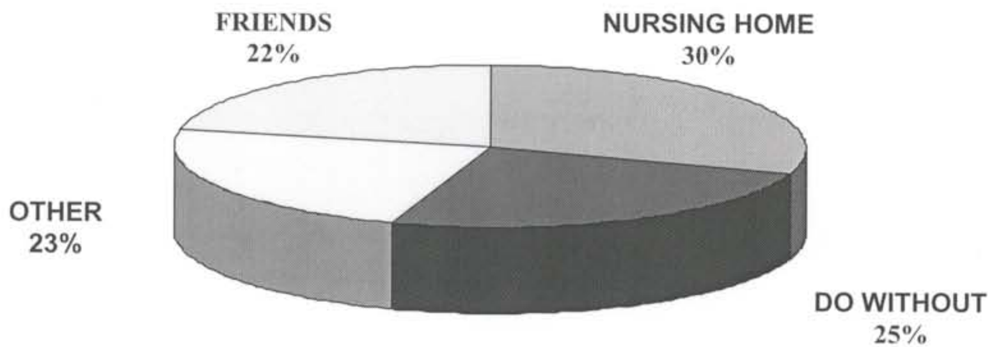
Fifty-eight percent (58%) of those completing the survey were program clients, thirty-four percent (34%) were family members, two percent (2%) were caregivers and another five percent (5%) were identified as others. Six percent (6%) of survey respondents did not provide an answer.



RESPONDENT CHARATERISTICS

B. CHCPE Alternatives

Eighty-eight percent (88%) of all survey respondents shared how they would manage without home care services. Thirty percent (30%) of these respondents reported they would have to enter a nursing home. Twenty-five percent (25%) said they would do without home care services and twenty-two percent (22%) reported they would depend on friends for help. Another twenty-three percent (23%) of those responding said they would rely on some other home care alternative.

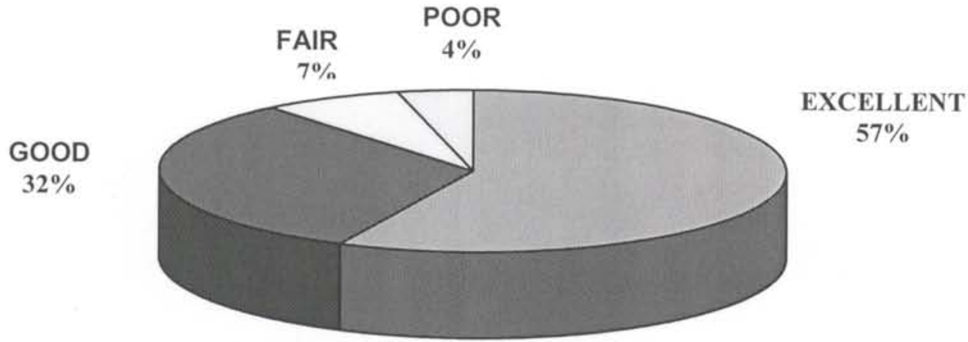


CHCPE HOME CARE ALTERNATIVES

C. Service Satisfaction

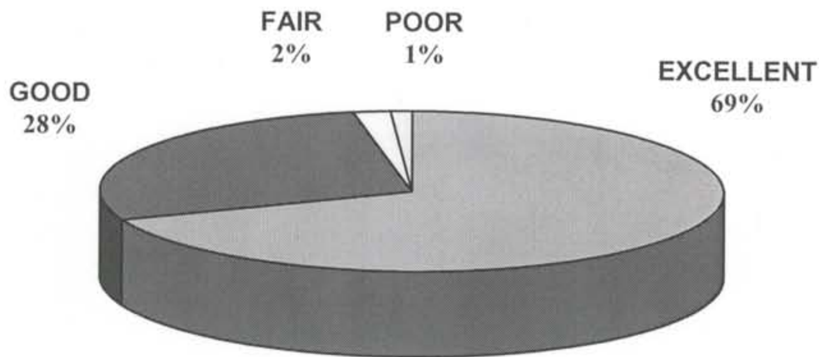
CHCPE clients participating in the survey rated the services they received positively. Eighty-nine percent (89%) reported all program services as "excellent" or "good". Eleven percent (11%) rated CHCPE services either "fair" or "poor".

APPENDIX F-3

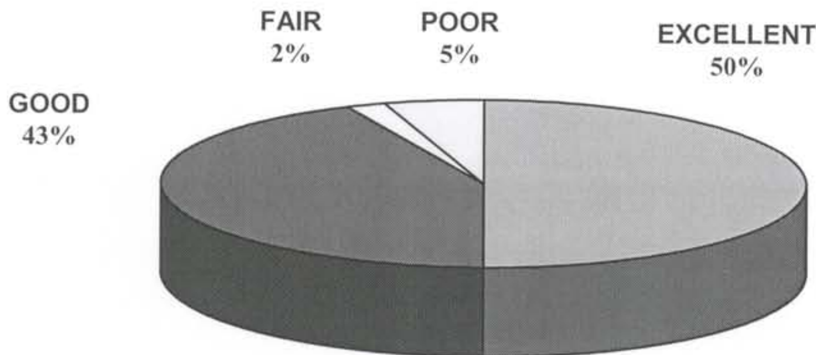


SERVICE SATISFACTION

Five (5) of the nine (9) identified CHCPE services were rated as "excellent" or "good" by eighty-nine percent (89%) of survey respondents. Eight (8) of the nine (9) identified services were rated as "excellent" or "good" by at least eighty-seven percent (87%) of survey respondents.



SKILLED NURSING



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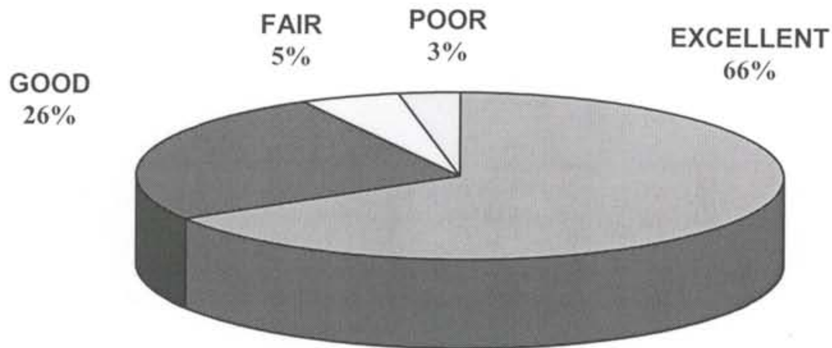
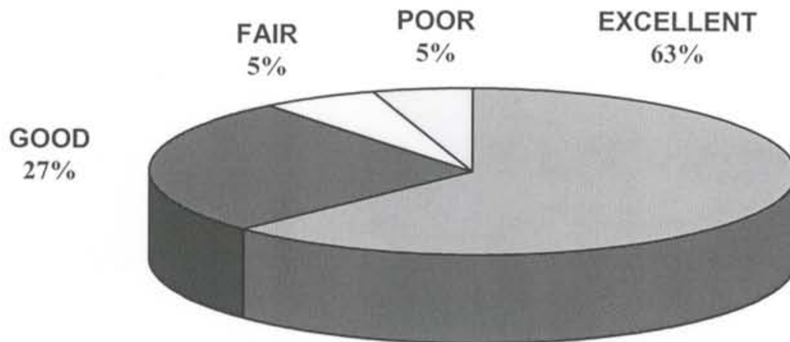
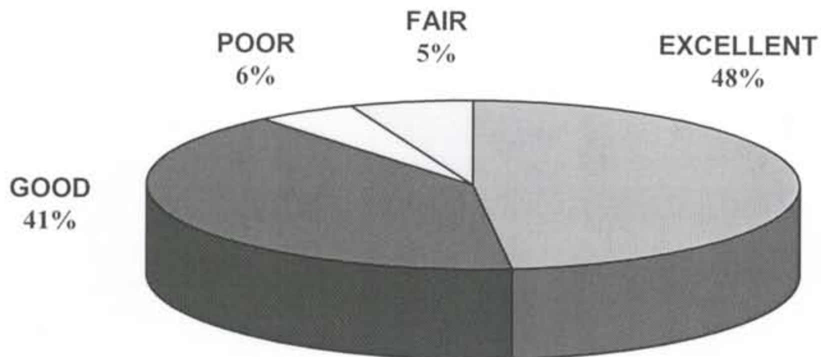
ADULT DAY CARE



EMERGENCY RESPONSE SYSTEM



HOME HEALTH AIDE



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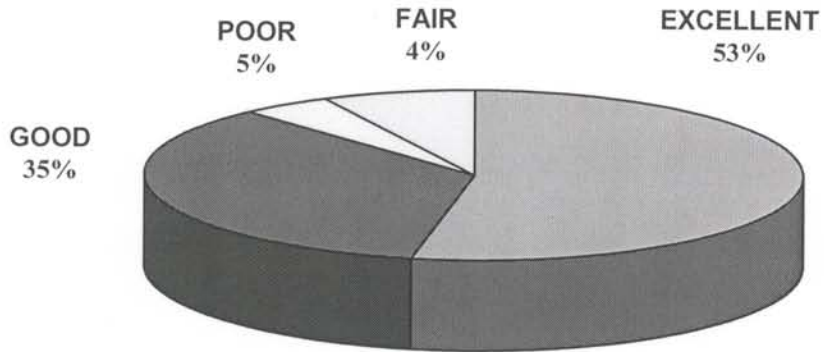
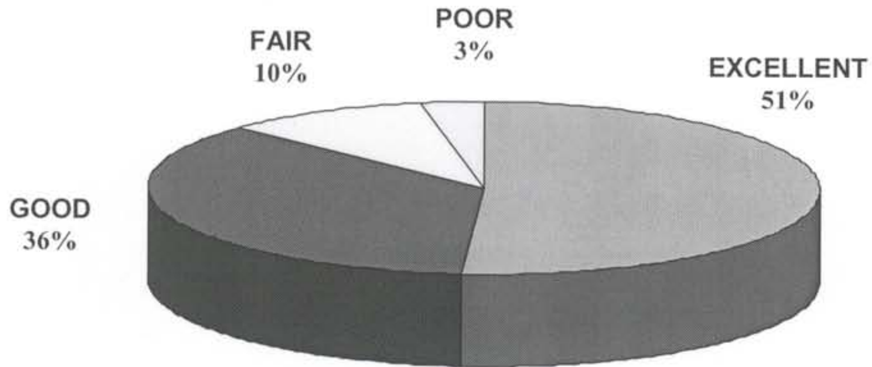
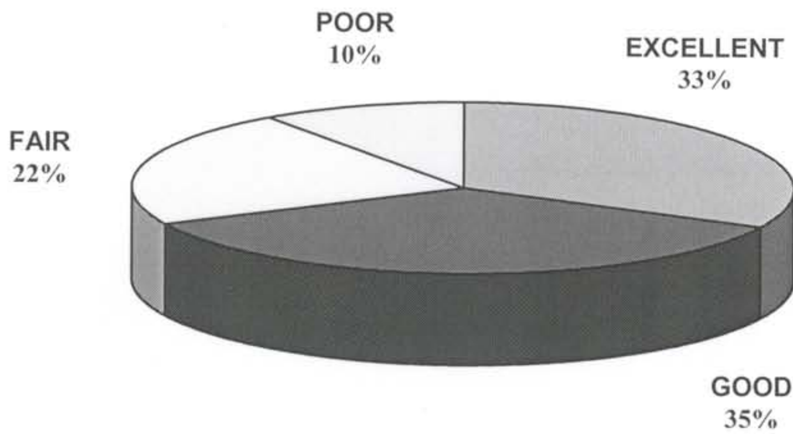
COMPANION



CHORE

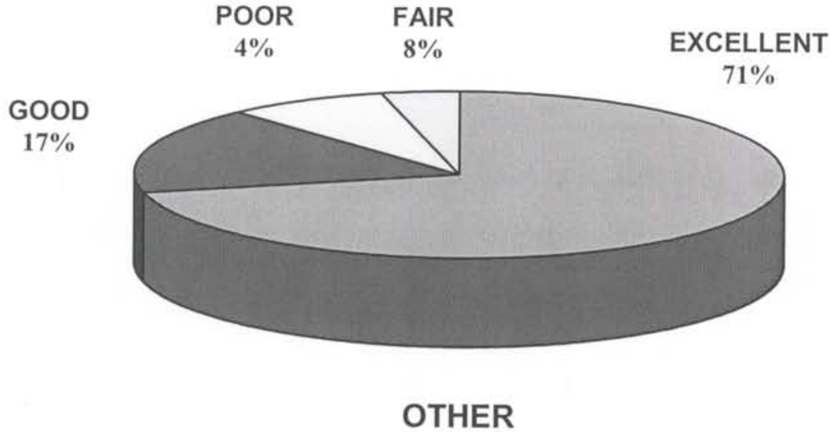


HOMEMAKER



MEALS ON WHEELS

Ten percent (10%) also rated non-identified services they were receiving through the CHCPE program. These services were categorized as "other" on the survey. Eighty-eight percent (88%) rated these services as "excellent" or "good".

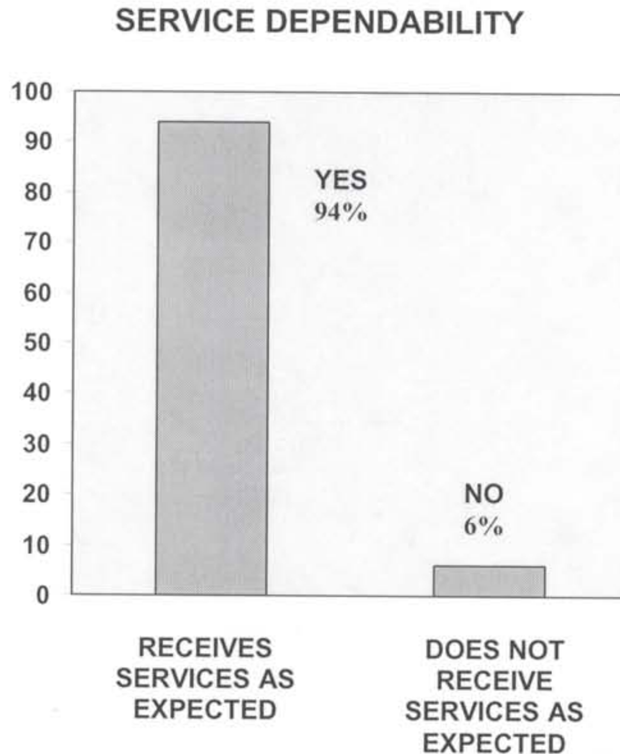


OTHER

D. Service Dependability

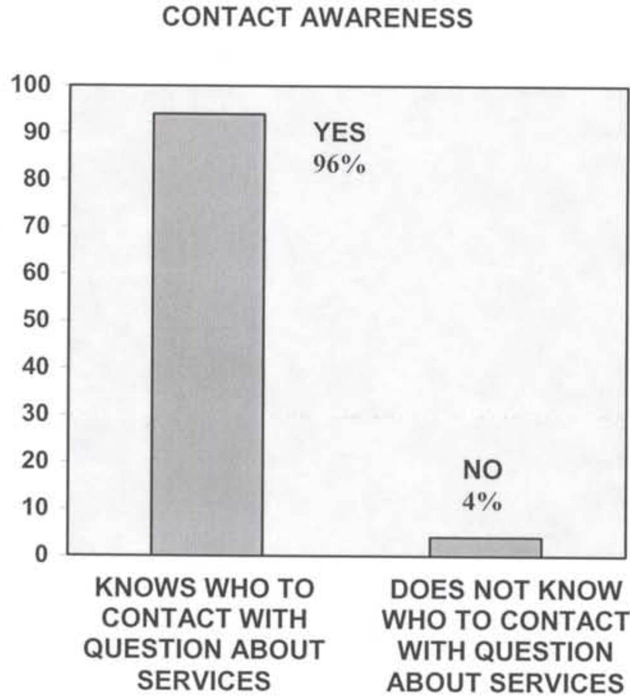
Ninety-four percent (94%) of all respondents reported that they received services when they were scheduled. Six percent (6%) reported not being able to depend on receiving services as scheduled.

SERVICE DEPENDABILITY



E. Contact Awareness

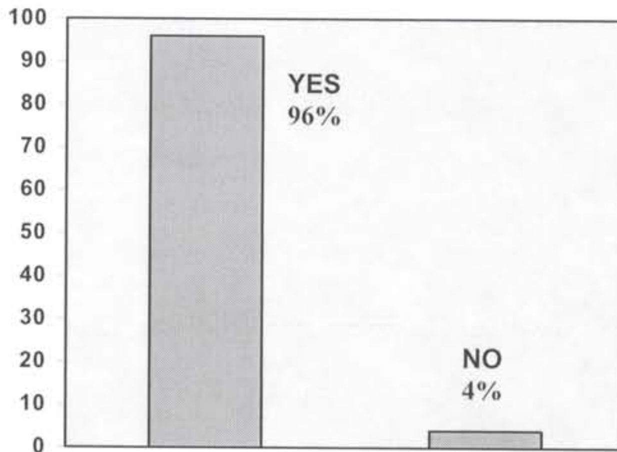
Ninety- six percent (96%) of respondents reported they know who to contact if they have a question about their services. Four percent (4%) reported they do not know who to contact.



F. CHCPE and Meeting Client Home Care Needs

Past client satisfaction surveys have asked respondents indirectly if the program meets the client's home care needs. The 2005 survey has been modified to directly ask the question "Does the home care program meet your home care needs?" Ninety-six percent (96%) of the survey respondents reported that the program does meet client needs.

CHCPE MEETING CLIENT HOME CARE NEEDS

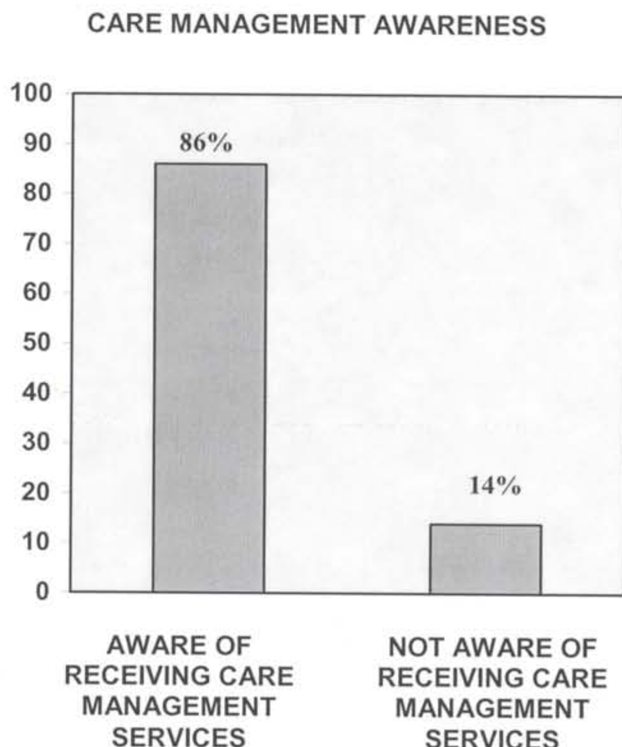


F. Care Management Awareness

Care management provides the client with a comprehensive assessment of the client's home care needs, identifies qualified providers, arranges for the services to be delivered and regularly monitors for changes in a client's needs and his/her satisfaction with services.

All surveyed clients receive care management services. Eighty-six percent (86%) reported receiving care management services. Consequently, fourteen percent (14%) of the respondents were either not aware that they were receiving the service or were unable to identify those services as care management.

CARE MANAGEMENT AWARENESS

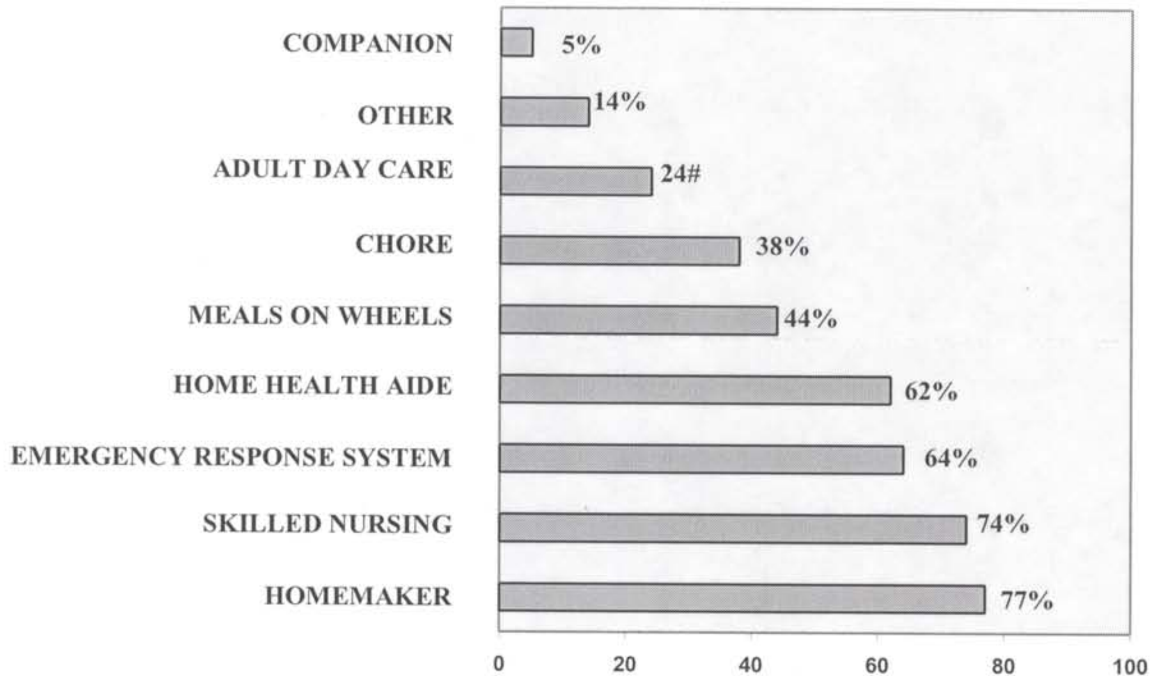


G. CHCPE Service Utilization

Service utilization is assumed when a respondent rates a particular service on the survey. Conversely, services not rated by the respondent are considered services the client does not receive. The analysis of service utilization is limited to the number of clients reporting receiving the service and does not include how often the services are received in a given amount of time. Care management services are not included in the analysis since all survey participants receive care management services.

Seventy-seven percent (77%) of survey respondents reported receiving homemaker services making it the most frequently reported service. Skilled nursing was the second most frequently reported service with seventy-four percent (74%). The third most frequently reported service was emergency response system services, which

was reported by sixty-four percent (64%) of survey participants, followed by home health aide with sixty-two percent (62%), meals on wheels with forty-four percent (44%), chore services with thirty-eight percent (38%), adult day care with twenty-four percent (24%), and companion with five percent (5%). Fourteen percent (14%) of all respondents reported receiving a service not identified by the survey.



IV. Comparative Results: North Western CT Client Satisfaction Surveys May 2001 & September 2006

A client satisfaction survey was conducted in May 2001 for the North Western Region. The 2001 survey was essentially the same survey as the 2005 except that fewer surveys, two hundred twenty-five (225), were mailed in 2001 and the survey instrument was modified slightly in 2005. The client response to the 2001 was higher than the 2005 survey in that forty-five percent (46%) of the survey population returned completed surveys compared to thirty-seven percent (37%) in 2005.

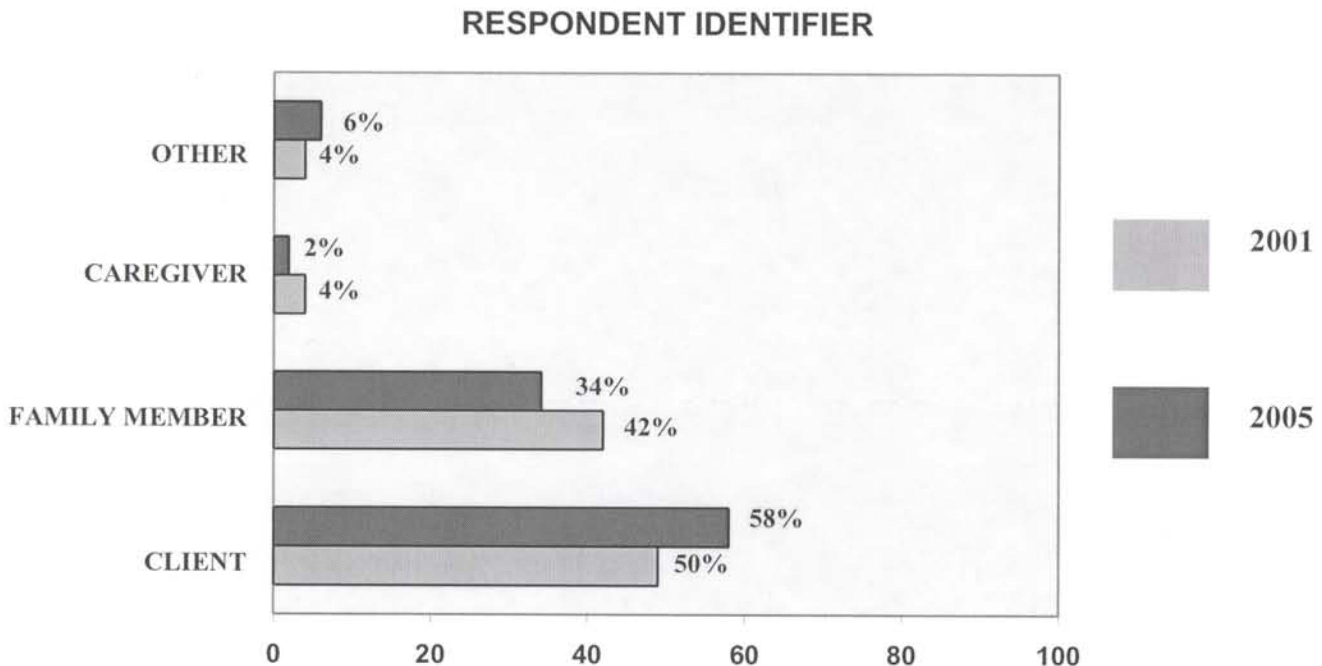
Survey Population and Response Rate	2001	2006
Average Regional Client Population	3,306	4,775
Number of Surveys Mailed	225	475
Percentage of Region's Client Population Surveyed	6.8%	10%
Percentage of Medicaid Clients Surveyed	68%	63%
Percentage of State Funded Clients Surveyed	32%	37%
Percentage of Surveys Returned	46%	37%

A study was conducted to examine the similarities and differences in responses between the North Western Region client satisfaction surveys conducted in May 2001 and September 2005. The purpose of the comparison study was to identify significant changes in the responses from the 2001 and 2005 surveys that indicated an improvement or decline in client satisfaction overall and with specific CHCPE services[1].

A. Respondent Identifier

The client satisfaction surveys asked who completed the survey, the client or a client representative. Significantly more of the North Western Region's clients completed the questionnaire in 2005 than 2001. Fifty-eight percent (58%) of the North Western Region's clients completed the survey compared to fifty percent (50%) in 2001. Family members were significantly less likely to complete the 2005 survey than respondents in 2001. They represented thirty-four percent (34%) of the 2005 respondents versus forty-two percent (42%) in 2001.

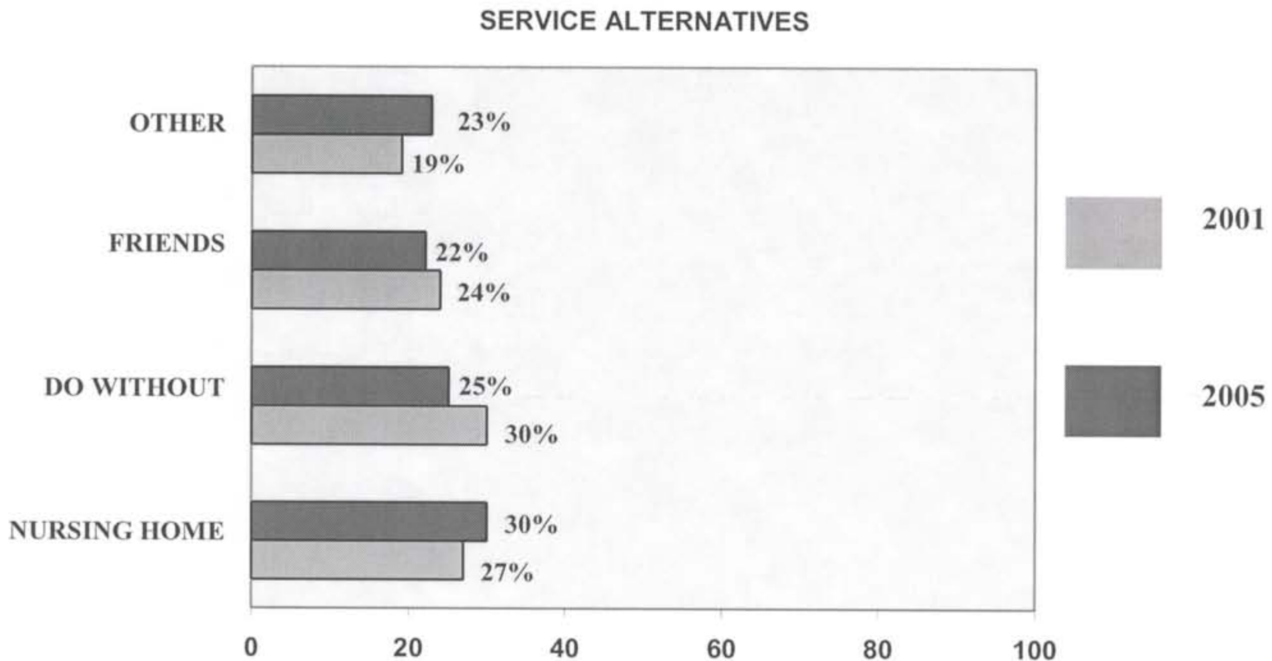
Slightly fewer caregivers completed the survey in 2005 than in 2001. Caregivers completed two percent (2%) of all surveys in 2005 compared to four percent (4%) in 2001. Six percent (6%) of North Western Region survey respondents identified themselves as "other" than the client, family member or caregiver versus four percent (4%) of respondents in 2001.



[1] Significant is defined as a difference in responses being greater than or equal to five percent (5%).

3B. CHCPE Service Alternatives

The client satisfaction surveys asked how clients would manage if they did not receive CHCPE services. Slightly more of the 2005 survey respondents reported they would enter a nursing home than the 2001 respondents. Thirty percent (30%) of the 2005 respondents reported they would enter a nursing home compared to twenty-seven percent (27%) of respondents from 2001. Twenty-five percent (25%) of the 2005 respondents reported that they would "do without" home care services, five percent less than the thirty-percent (30%) reported in 2001. Twenty-two percent (22% of respondents reported they would turn to friends for help in 2005 whereas twenty-four percent (24%) said they would turn to friends in 2001. Twenty-three percent (23%) reported they would turn to a service alternative other than the options provided by the survey in 2005. Nineteen percent (19%) identified "other" as their service alternative in 2001.



A. Quality of Services

There was no significant difference found in the overall quality of services from the North Western Region 2001 and 2005 survey results. Ninety-one percent (91%) of the 2001 North Western Region respondents rated all CHCPE services as either "excellent" or "good" compared to eighty-nine percent (89%) of the 2005 survey respondents.

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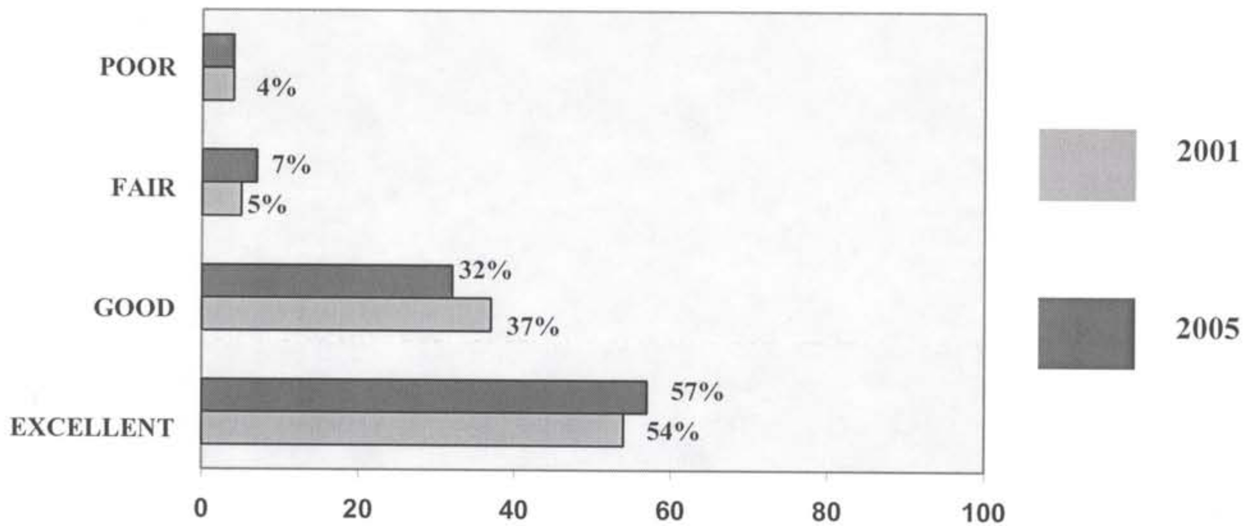
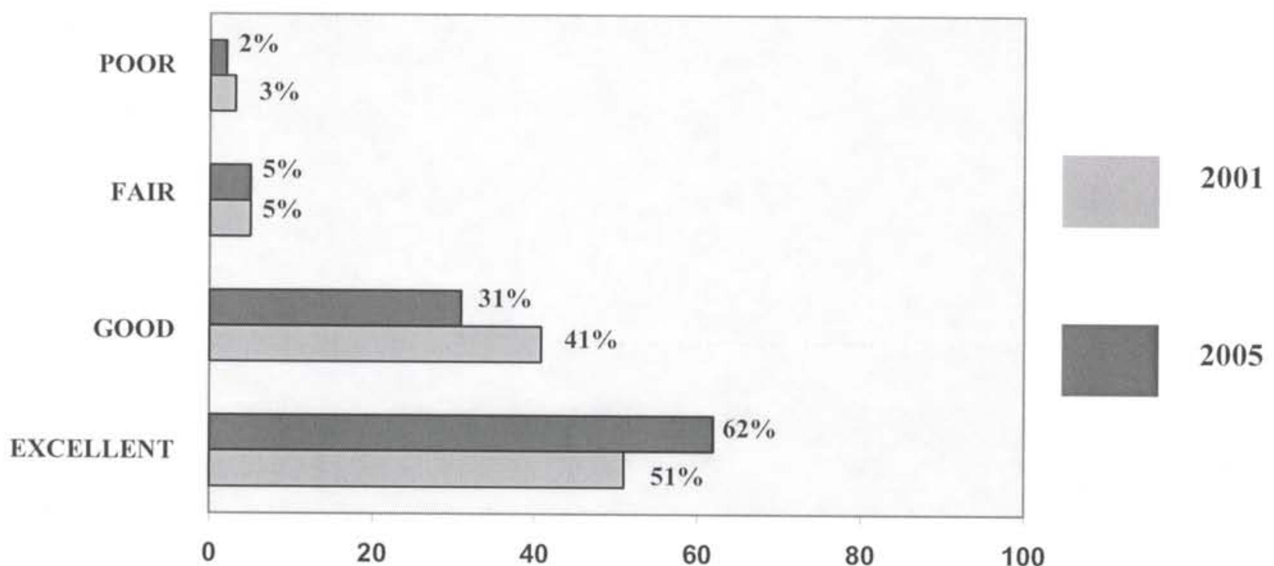
OVERALL QUALITY OF SERVICES



North Western Region 2005 survey respondents rated specific CHCPE services very similarly as the Region's 2001 respondents. However, some significant differences were noted. Eleven percent (11%) more survey respondents rated care management services as "excellent" in 2005 than in 2001. Meals on wheels was rated significantly less favorably in the 2005 survey with twelve percent (12%) more survey respondents rating the service as either "fair" or "poor". Participant rating for homemaker services also indicated a significant decline in client satisfaction with five percent (5%) more of survey respondents rating this service as either "fair" or "poor" than respondents in the 2001 survey.

CARE MANAGEMENT

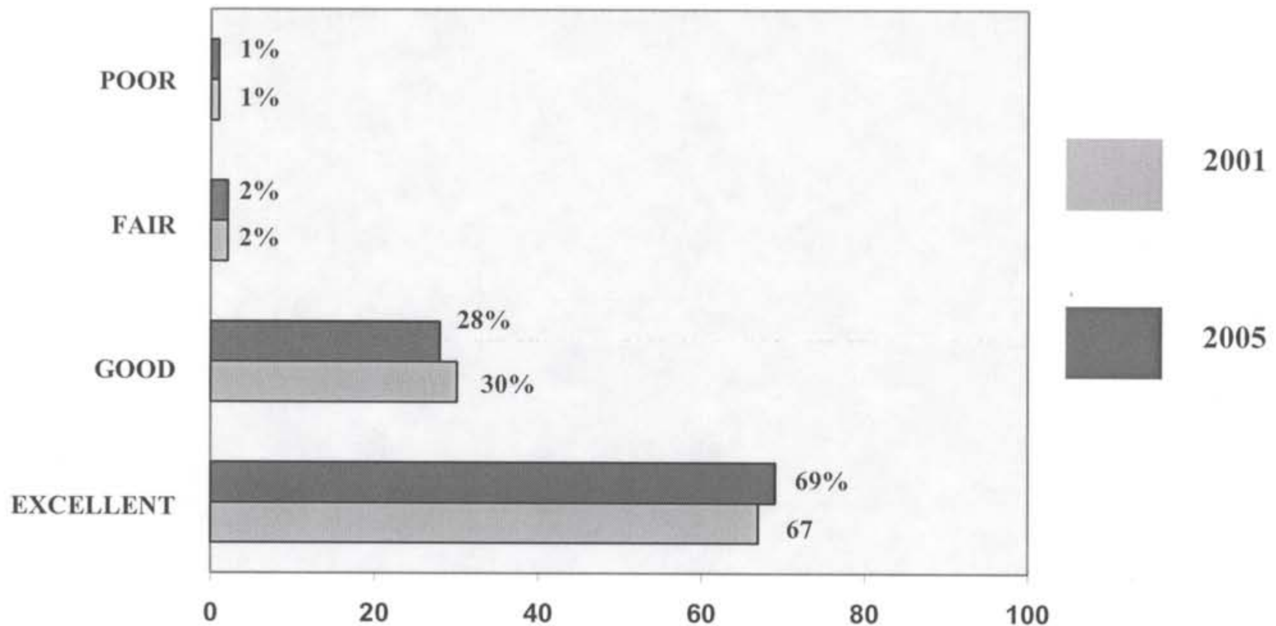
Ninety-three percent (93%) of 2005 survey respondents rated care management as either "excellent" or "good" compared to ninety-two percent (92%) of respondents in 2001.



APPENDIX F-13

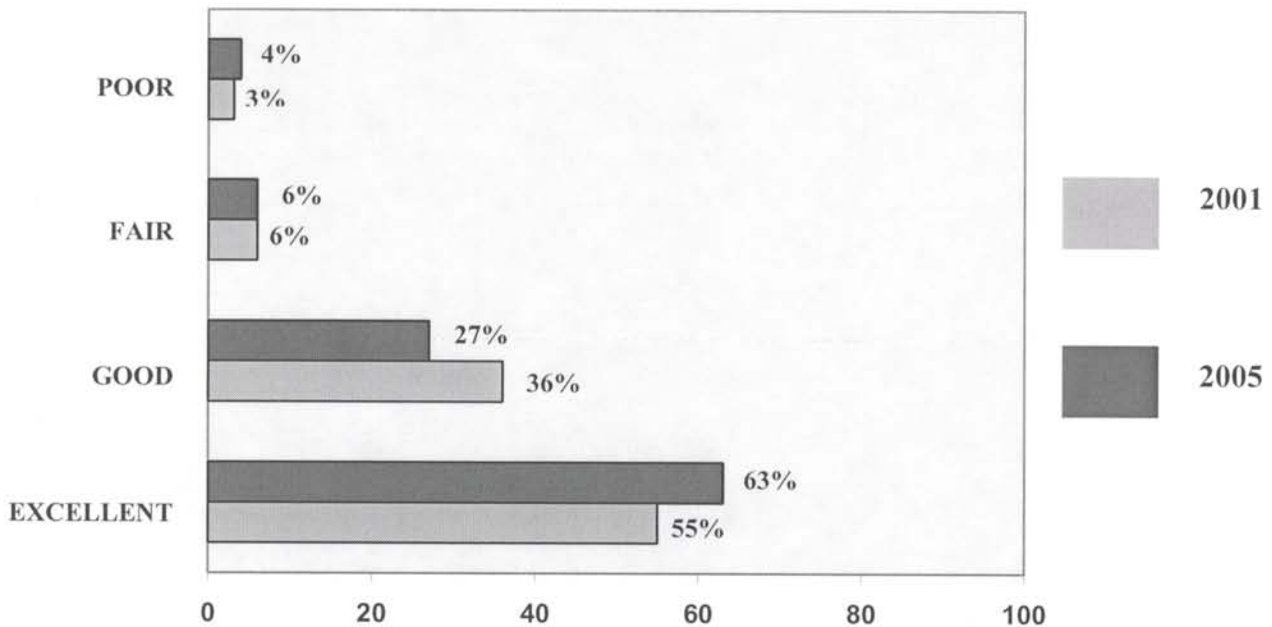
SKILLED NURSING

Ninety-seven percent (97%) of survey respondents rated skilled nursing services as either "excellent" or "good" in both the 2005 and 2001 surveys.



HOME HEALTH AIDE

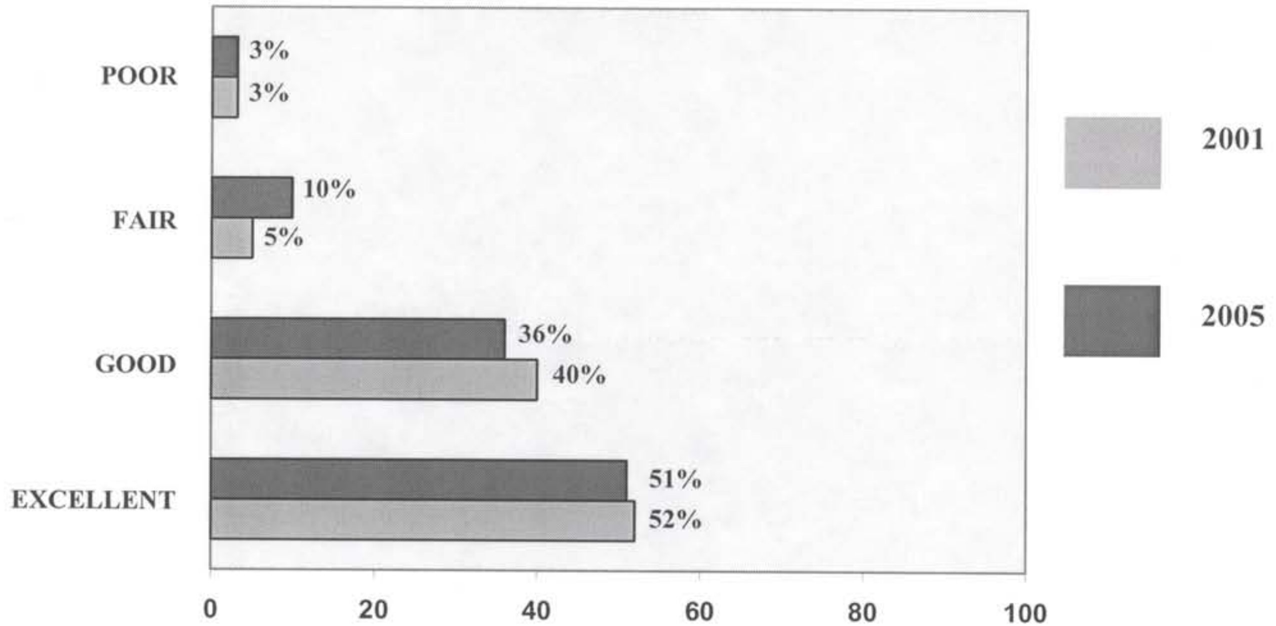
Home health aide services were rated "excellent" or "good" by ninety percent (90%) in 2005 and ninety-one percent (91%) in 2001.



APPENDIX F-14

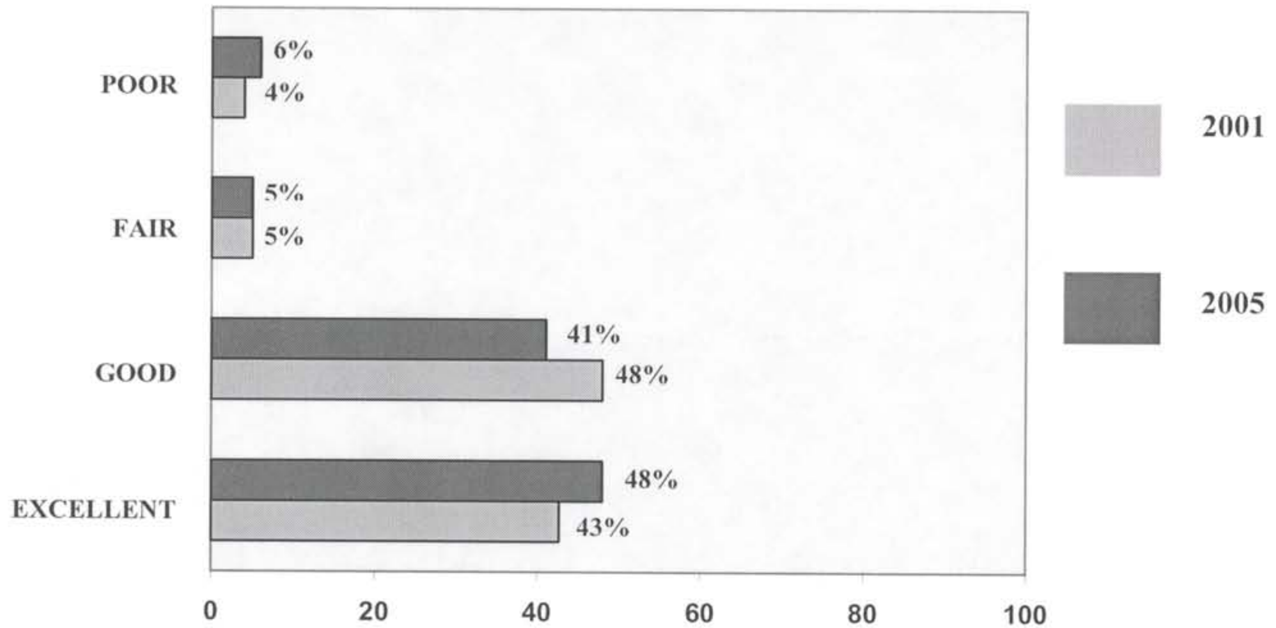
HOMEMAKER

Eighty-seven (87%) of survey participants rated homemaker services as "excellent" or "good" in 2005 compared to Ninety-two percent (92%) in 2001.



COMPANION

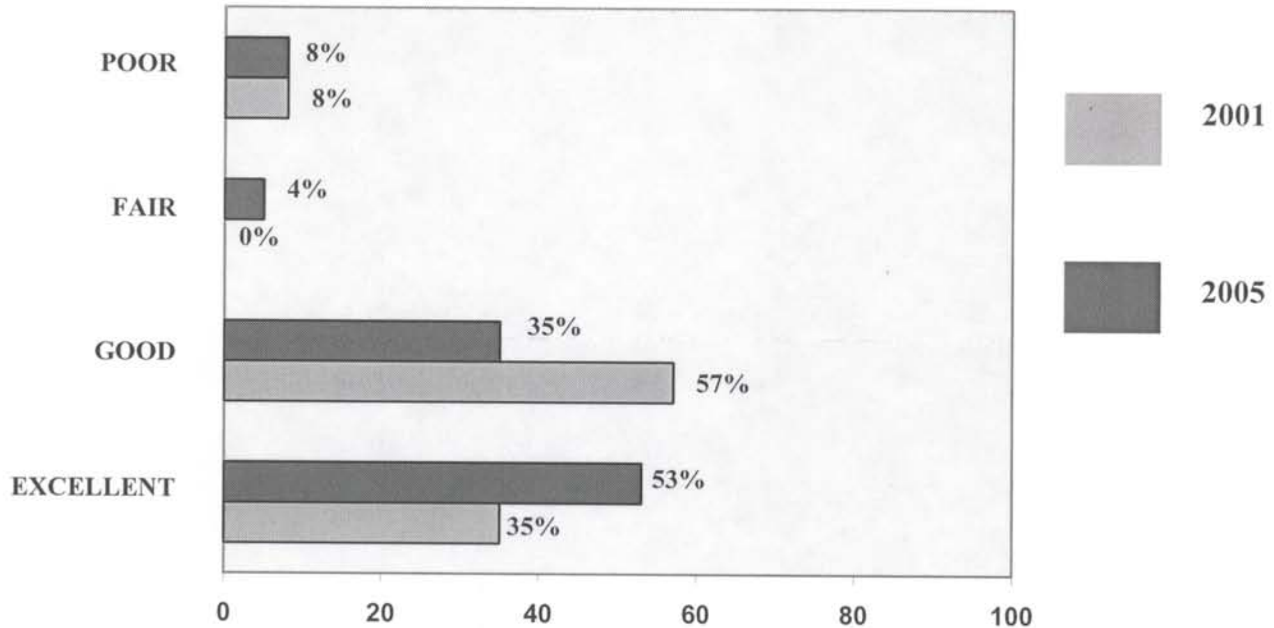
Companion services were rated as either "excellent" or "good" by eighty-nine percent (89%) of 2005 survey participants. Ninety-one percent (91%) of 2001 of survey participants in the 2001 survey rated companion services as either "excellent" or "good"



APPENDIX F-15

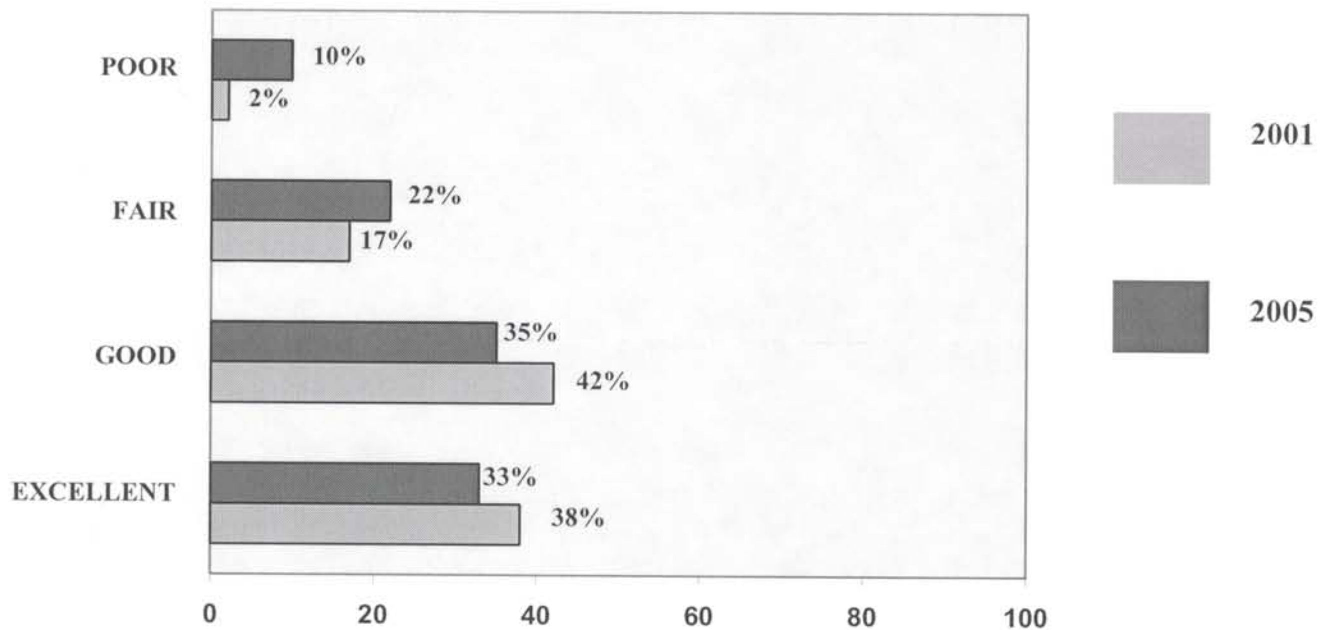
CHORE

Ninety-two percent (92%) of 2001 survey respondents rated chore services as either "excellent" or "good" compared to eighty-eight percent (88%) of 2005 respondents



MEALS ON WHEELS

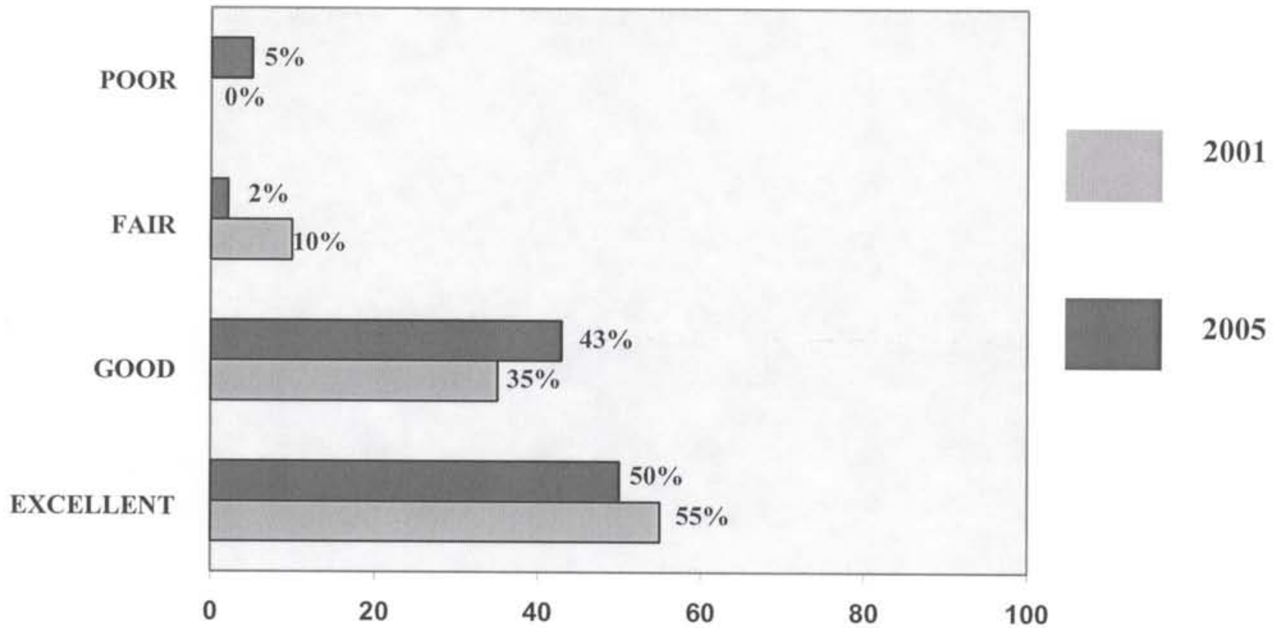
Participants in both the 2001 and 2005 surveys rated the meals on wheels service as the CHCPE service in most need of improvement. Sixty-eight percent (68%) of survey respondents rated meals on wheels as either "excellent" or "good" in 2005 compared to eighty percent (80%) in 2001.



APPENDIX F-16

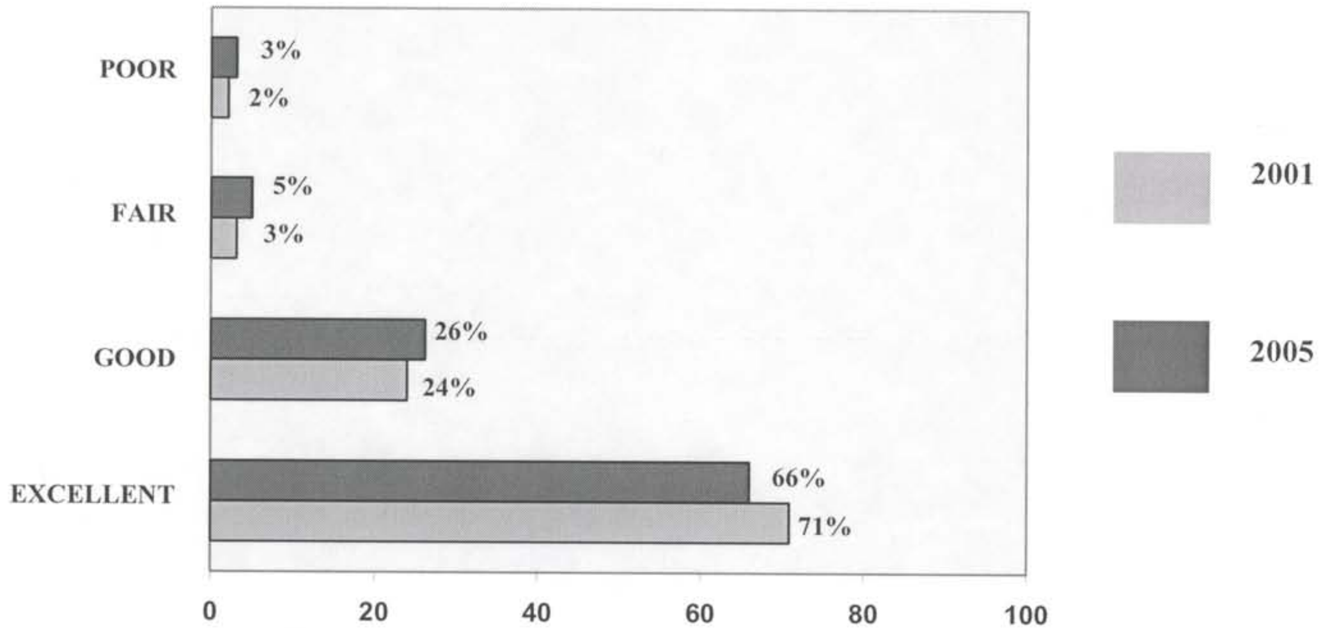
ADULT DAY CARE

Ninety-three percent of 2005 survey participants rated adult day care services as either "excellent" or "good". Ninety percent rated the services as "excellent" or "good" in 2001.



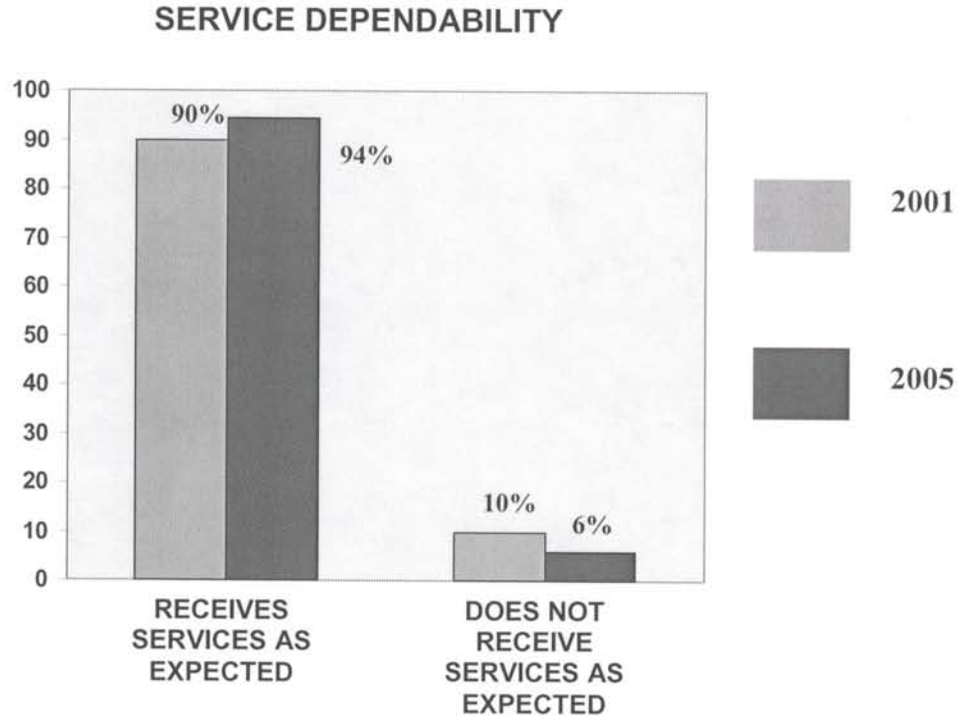
EMERGENCY RESPONSE SYSTEM

Ninety-two percent (92%) of survey respondents rated their emergency response system as either "excellent" or "good" in 2005 compared to ninety-five percent (95%) of survey respondents in 2001.



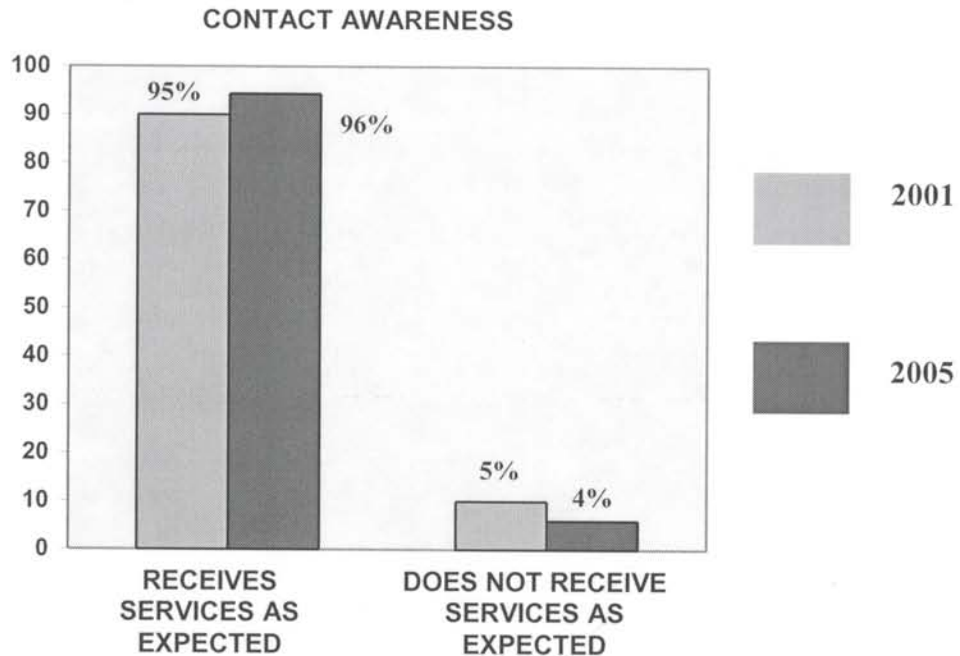
B. Service Dependability

North Western Region survey participants reported receiving services as scheduled more frequently than they reported in the 2001 survey. Ninety-four percent (94%) of the 2005 North Western Region respondents reported being able to depend on receiving services as scheduled compared to ninety percent (90%) of the 2001 respondents.



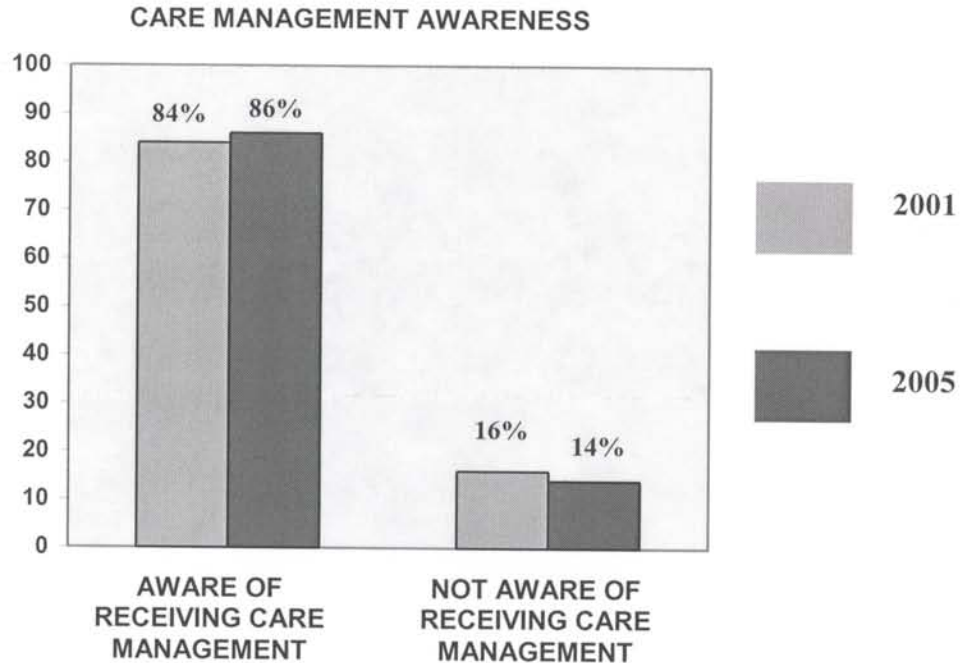
C. Contact Awareness

Ninety-six percent (96%) of respondents from the 2005 North Western Region survey reported knowing who to contact if they have a question about their services compared to ninety-five percent (95%) of respondents in 2001.



D. Care Management Awareness

Survey respondents from the North Western Region were slightly more aware of receiving care management services in 2005 than in the last survey. Eighty-six percent (86%) of the North Western Region survey participants reported receiving care management services in 2005 compared to eighty-four percent (84%) in 2001.[2].



D. Service Utilization

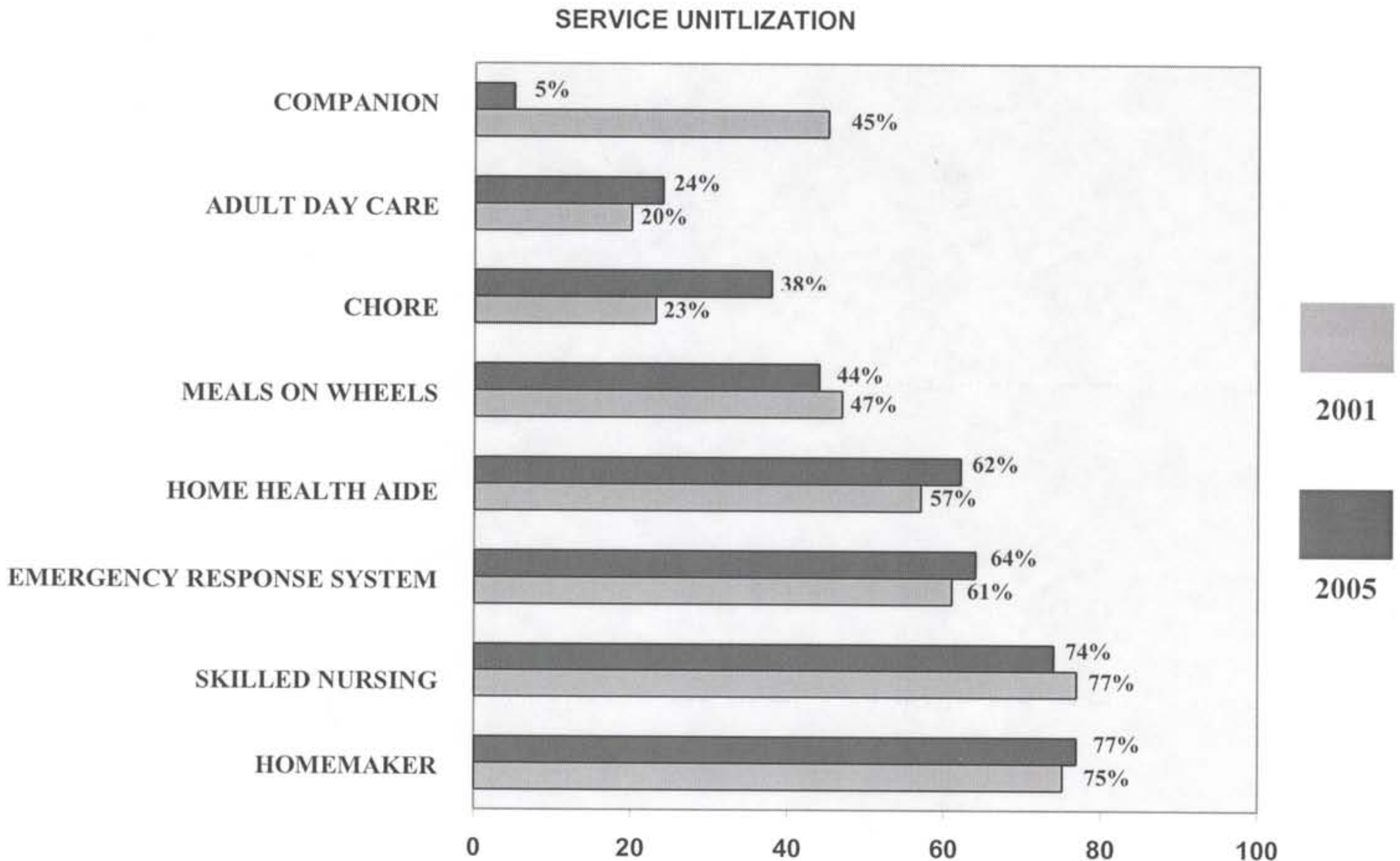
Service utilization is assumed when a respondent rates a particular service on the survey. Conversely, services not rated by the respondent are considered services the client does not receive. The analysis of service utilization is limited to the number of clients reporting receiving the service and does not include how often the services are received. Care management services are not included in the analysis since all survey participants receive care management services.

The North Western Region 2005 survey respondents reported a significantly lower utilization of companion services than did the survey respondents in 2001. Forty-five percent (45%) of survey participants reported receiving companion services in 2001 while only five percent (5%) reported using companion services in 2005. Thus, forty percent (40%) fewer respondents reported receiving companion services.

Insignificant decreases in service utilization were reported for skilled nursing services and meals on wheels. Seventy-seven percent (77%) reported using skilled nursing services in 2001 compared to seventy-four percent (74%) in 2001. Utilization of meals on wheels services also declined by three percent (3%) with forty-seven percent (47%) reported using this service in 2001 versus forty-four percent (44%) in 2005.
Five (5) CHCPE services showed an increased utilization of services. A significantly larger

[2] Self Directed Care Clients do not receive care management services and are not included in care management awareness data.

number of respondents reported receiving chore services in 2005 than respondents in 2001. Thirty-eight percent (38%) of the 2005 respondents reported receiving chore services versus twenty-three percent (23%) in 2001. Thus, fifteen percent (15%) more survey participants reported using chore services in 2005 than in 2001. Survey respondents also reported a five percent (5%) increase in home health aide services in 2005 than respondents in the 2001 survey. Utilization of three (3) other CHCPE services were reported slightly higher in 2005 than in 2001. Adult day care utilization was up by four percent (4%), emergency response system by three percent (3%), and homemaker by two percent (2%).



E. Summary and Conclusions

The Alternate Care Unit, CT Department of Social Services, administered a client satisfaction survey for the CHCPE in September 2005. Four hundred seventy-five (475) clients in the CT Home Care Program North Western Region were surveyed. One hundred seventy-five (175) or thirty-seven percent (37%) of surveyed clients responded to the survey. The survey's response rate rises to forty-four percent (44%) when undelivered surveys are deducted from the total number of surveys mailed. Program clients completed more than half of the returned surveys. Family members were the second most frequent survey responders accounting for slightly over a third followed by caregivers and "others".

The satisfaction survey demonstrated that a significant number of clients residing in the CHCPE North Western Region believe they are receiving quality home care services. Eighty-nine percent (89%) reported all program services as "excellent" or "good". Eight of the nine (9) identified CHCPE services were rated "excellent" or "good" by at least eighty-seven percent (87%) of survey respondents.

Homemaker, skilled nursing and emergency response system services are the most commonly used services in the North Western Region.

Ninety-four percent (94%) of the participants in this survey reported that they can depend on receiving services as expected and ninety-six percent (96%) know who to contact if they have a question about their services. Fifty-five-percent (55%) stated, without the availability of the CHCPE services, they would have to either enter a nursing home or do without. Forty-five percent (45%) reported they would turn to friends for help or seek assistance from a source not identified by the survey.

A comparison analysis of the North Western Region 2005 client satisfaction survey results and the results from the 2001 North Western Region satisfaction survey was conducted. The purpose of the comparison study was to identify significant changes in the responses from the 2001 and 2005 surveys that indicated an improvement or decline in client satisfaction overall and with specific CHCPE services

Significantly more North Western Region clients completed the questionnaire in 2005 than 2001. Family members were significantly less likely to complete the 2005 survey than respondents in 2001.

Survey participants were asked what they would do if the CHCPE was unavailable. Slightly more of the 2005 survey respondents reported they would enter a nursing home than the 2001 respondents. Slightly less reported that they would turn to friends for help or do without home care services in 2005 than in 2001

There was no significant difference found in the overall quality of services from the North Western Region 2001 and 2005 survey results. However, some significant differences were noted. Significantly more survey respondents, rated care management services as "excellent" in 2005 than in 2001. Meals on wheels and homemaker services were rated significantly less favorably in the 2005 survey than in the 2001 survey.

The comparative study found that there was no significant change in clients' utilization of five (5) of the eight (8) identified program services. Three (3) services did show significant changes in utilization: companion services; chore services; and homemaker services. There was a significant decrease in companion services (40%) as well as a significant increase in chore services (15%) from 2001 and 2005. Homemaker service utilization was also reported higher in 2005 by five percent (5%).

The survey results suggest four (4) areas of focus where the North Western Region of the CHCPE has potential for improvement: (1) increase participant satisfaction with meals on wheels and (2) homemaker services; (3) increase client awareness of care management services; and (4) explore possible strategies to decrease the number of incorrect and/or insufficient addresses in the program's database.

The North Western Region client satisfaction survey indicated a significant drop with

CHCPE client satisfaction with the meals on wheels service. In 2001, eighty percent (80%) of survey respondents rated meals on wheels as either "excellent" or "good". This percentage fell to sixty-eight percent (68%) in 2005.

Homemaker services also showed a decrease in client satisfaction between 2001 and 2005. Ninety-two percent (92%) of survey respondents rated homemaker services as either "excellent" or "good" compared to eighty-seven percent (87%) in 2005.

Respondent awareness of care management services increased slightly from 2001 and 2005 rising from eighty-four percent (84%) in 2001 to eighty-six percent (86%) in 2005. Still, fourteen percent (14%) of survey respondents did not report an awareness of receiving care management services.

The final area of focus is to explore possible strategies to decrease incorrect and/or insufficient address information in the program's database. Seventeen percent (17%) of all mailed surveys were returned undelivered. An incorrect address was by far the most common reason the surveys were undeliverable, accounting for more than ninety percent (90%) of all returned surveys.

IV. Alternate Care Unit Client Satisfaction Surveys Resultant Follow-up and Intervention

A. ACU staff contacts, by telephone, all survey participants who provided their names and telephone numbers and:

- rated one or more of the CHCPE services as either "fair" or "poor";
- reported not knowing who to contact if they had a question about their services; and/or
- did not indicate an awareness of receiving this service by rating its quality on the survey instrument.

1. Rated one or more of the CHCPE services as either "fair" or "poor"

   Participants who rate one or more of their CHCPE services as either "fair" or "poor' are asked to share their experience(s) that resulted in the participant rating a service as "fair" or "poor." These participants are also asked if they informed their care manager that they felt a service(s) was less than good. Survey participants who report they did not share their experience(s) with their care manager are encouraged to do so.

   Participants who respond that they did report their dissatisfaction are asked what action was taken by their care manager to address the problem and if that action resulted in improved service. ACU staff follow-up with the appropriate care manager if the respondent reported that the problem with a provider was not adequately resolved.

2. Reported not knowing who to contact if they had a question about their services and
3. Did not indicate an awareness of receiving this service by rating its quality on the survey instrument.

ACU staff identifies the care managers for survey participants who did not report receiving care management services and/or did not know who to contact if they had a question. The care managers are contacted individually and asked to contact the participant to educate them regarding their role as care manager and/or ensure they knew how to contact them if they had a question or complaint about their CHCPE services.

B. The appropriate access agency is given a summary of the survey results. The access agency is asked to provide the Department with an intervention plan to address the area(s) identified by the survey as amenable to improvement. The access agency is provided with a summary of "fair" and/or "poor" ratings by town.

C. Inherent to the survey process is the identification of clients whose address or status is incorrect in the programs' database. Alternate Care Unit staff ascertains the correct address and/or change in client status and updates the programs' database.

D. Although corrective action may not be indicated, the Alternate Care Unit staff will work cooperatively with the Access Agencies to identify the factors behind a forty percent (40%) drop in the utilization of chore services in the North Western Region between 2001 and 2005.

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APPENDIX I

September 1, 2005

NAME
STREET
CITY, STATE, ZIP

Dear «FNAME» «LNAME»:

The Connecticut Home Care Program for Elders would like you to share your thoughts and opinions on the help that you are receiving from our program. Our goal is to provide you with quality services in your home.

We have enclosed a short survey about the quality of services you receive. We would appreciate your honest opinion on the program so that we can use your experiences to improve our services and the way they are delivered. Your participation in this survey is voluntary. If you choose to participate, providing us with your name is optional.

The opinions and experiences you share will be kept confidential and will not affect your care or services in any way.

Please complete the survey and return it to us in the enclosed self-addressed stamped envelope. We would appreciate hearing from you within the next 3 to 4 weeks.

Thank you for your assistance.

Sincerely,

Lyn Lanoue
Health Program Associate
1-800-445-5394

Esta carta y cuestionario estan disponibles en español. Si los desea en español, favor de llamar al 1-800-445-5394.

APPENDIX II

Connecticut Home Care Program For Elders
Client Survey

Which services do you receive?	How do you rate the quality of this service?
☐ Care Management	This service arranges and adjusts the services you need. The care manager contacts you on a regular basis to monitor your services. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Skilled Nursing	This service is provided when a nurse conducts medical activities such as checking your blood pressure. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Home Health Aide	This service is when someone helps you with personal care such as bathing and dressing. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Homemaker	This service helps with general household chores. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Companion	This service is when your care manager arranges for someone to spend time with you to talk. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Chore	This service provides help with heavy household chores and maintenance. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Meals on Wheels	This service brings prepared food to your home. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Adult Day Health	This is a place that offers services such as meals, recreation, and health monitoring to someone who is unable to stay home alone during the day. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Emergency Response System	This is a device that brings help to you in an emergency. ☐ Excellent ☐ Good ☐ Fair ☐ Poor
☐ Other (Please Identify)	This service is ______________________ ☐ Excellent ☐ Good ☐ Fair ☐ Poor

APPENDIX F-26

Do you receive all of your services when you are supposed to get them?

☐ Yes ☐ No

If no, please explain: ______________________________________

____

____

2. Do you know who to contact when you have a question about your services?

   ☐ Yes ☐ No

3. How would you manage without home care services?

   ☐ Help from friends ☐ Enter a nursing home ☐ Do without ☐ Other

4. Does the home care program meet your home care needs?

   ☐ Yes ☐ No

5. Please share any other comments that you might have about the CT Home Care Program for Elders.______________________________________

   ____

   ____

   ____

6. Who answered these questions?

   ☐ Client ☐ Family Member ☐ Caregiver ☐ Other

7. What town does the person receiving services live in? ________________

✪ If you would like to provide your name and telephone number, we may contact you to discuss the home care program. If you would like to call us to discuss the program, please call us on our toll free telephone number. (1-800-445-5394)

Name______________________________ Telephone No. ______________

Please return the completed survey in the enclosed, self-addressed stamped envelope by September 30, 2005.

Thank you for your input!

APPENDIX III

CHCPE Region I
North Western Connecticut
Client Satisfaction Survey
Administration Specifics

Number of surveys mailed: 475

Surveys sent: September 1, 2005

Return Date: September 30, 2005

Total CHCPE Region I population as of May 2005: 4,775

Total CHCPE program population as of May 31, 2005: 14,927

Percentage of regional population surveyed: 10%

Population Surveyed Representative of Program Population

North Western (NC) CHCPE Population			Survey Population		
	Total **Number**	**% of North Western Population.**		Total **Number**	**% of Survey Population**
	4,775	32%		475	100%
Category 3	2,949	62%**	Category 3	301	63%
Category 2	922	19%**	Category 2	84	18%
Category 1	904	19%**	Category 1	90	19%

APPENDIX F-28

APPENDIX IV

CHCPE Region I
North Western Connecticut
Client Satisfaction Survey

Breakdown of Undelivered Surveys

	Number	%
Surveys not delivered to targeted client	81	
Surveys returned because of incorrect address	73	90.12%
Surveys returned by post office because of an available mail receptacle	1	1.24%
Surveys returned because of insufficient address	2	2.47%
Surveys returned because client was "Temporarily away"""	1	1.24%
Surveys returned because client was deceased	2	2.47%
Surveys returned because client had entered a nursing facility	2	2.47%

Appendix G

Connecticut Home Care Program For Elders

Alternate Care Unit Mission

The mission of the Alternate Care Unit is to develop and offer cost-effective community-based and other long term care alternatives to individuals and families with continuing care needs and policies pertinent to long term care residents.

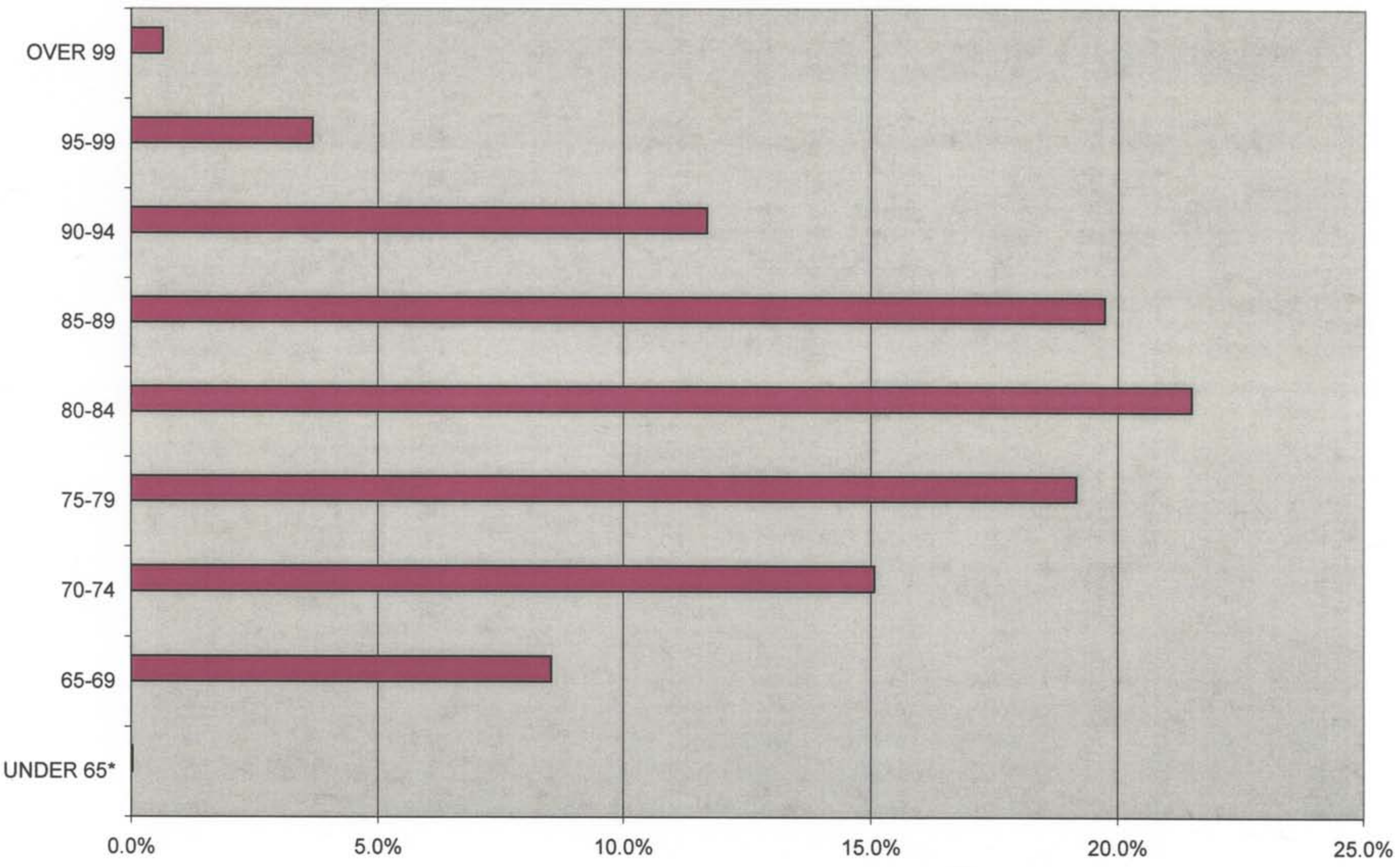
The activities of the Alternate Care Unit take place under the overall mission of the Connecticut Department of Social Services which is to serve families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self reliance and independent living.

On June 16, 2003, the Alternate Care Unit Field Office Operations were centralized at the Department of Social Services, 25 Sigourney St., 11th Fl., Hartford, Connecticut 06106.

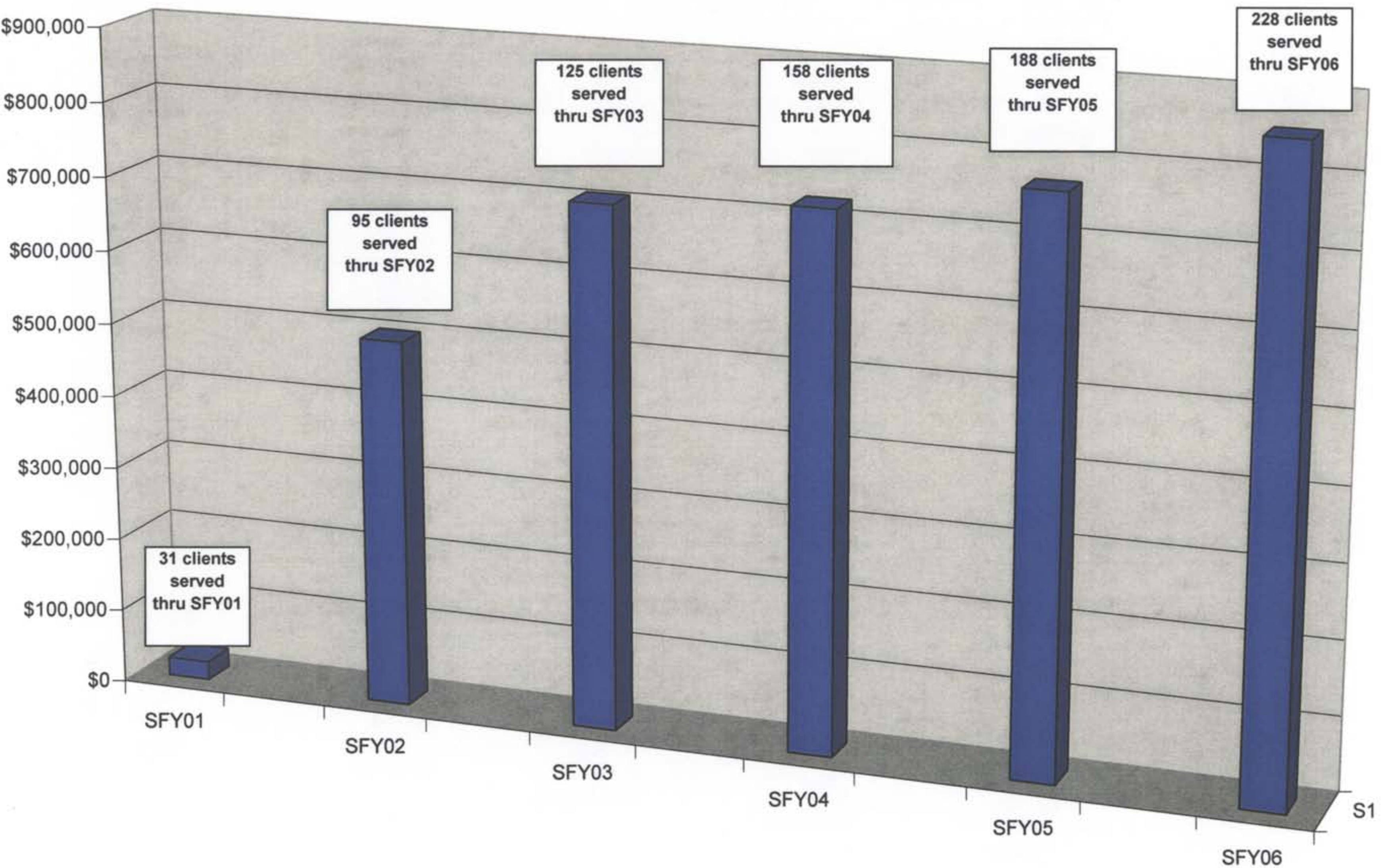
The Connecticut Home Care Program for Elders provides a wide range of home health and non-medical services to persons age 65 or older who are institutionalized or at risk of institutionalization. Available services include adult day health, homemaker, companion, chore, home delivered meals, emergency response systems, care management, home health, assisted living and minor home modification services. Personal care assistant services are also available under a state appropriation dependent on funding. In order to be eligible for the program, the individual must meet the income, asset and functional eligibility criteria of the CT Home Care Program for Elders.

To obtain information regarding the Connecticut Home Care Program for Elders or to make a referral, please contact the Department's toll free number 1-800-445-5394.

APPENDIX H

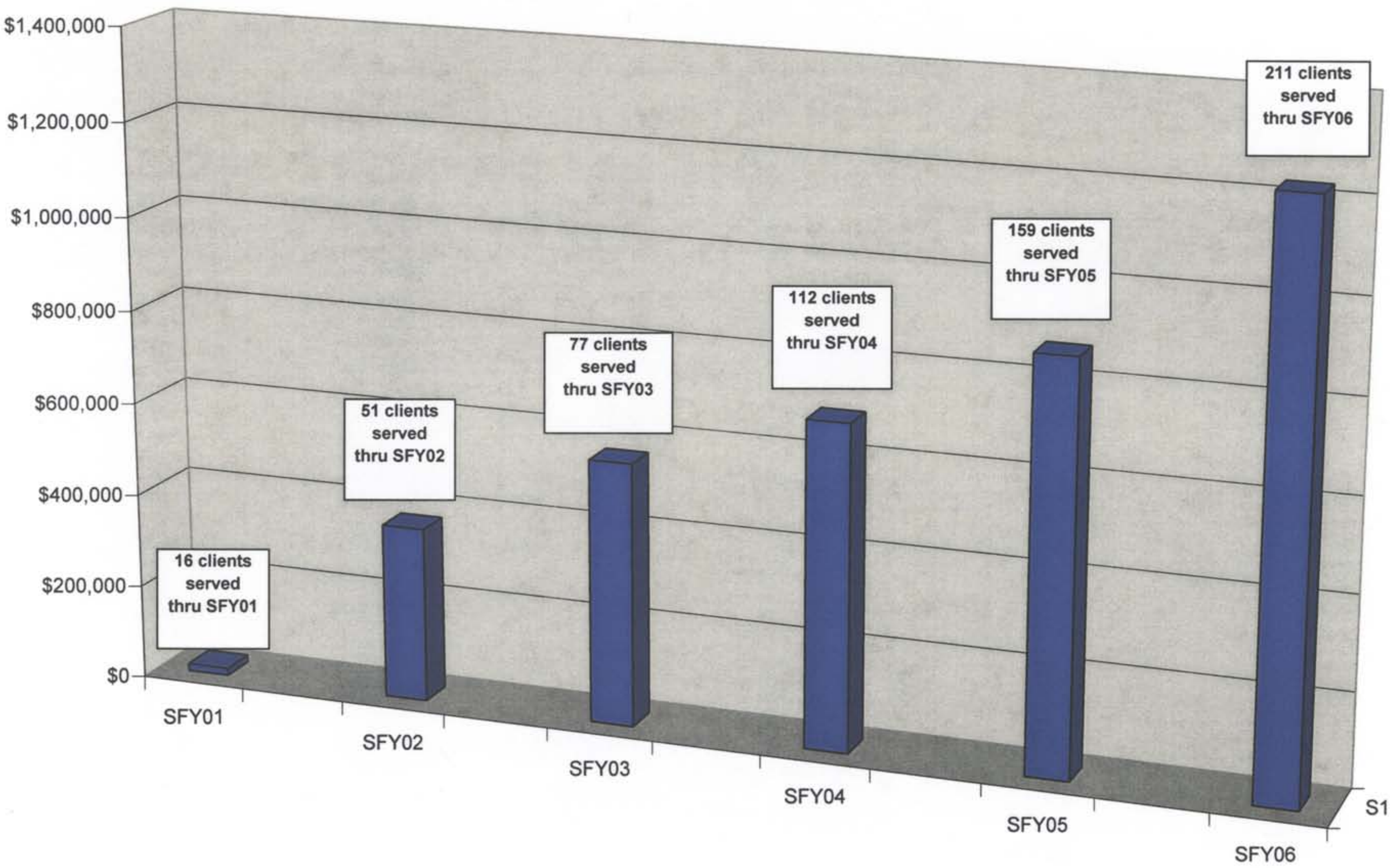


APPENDIX I



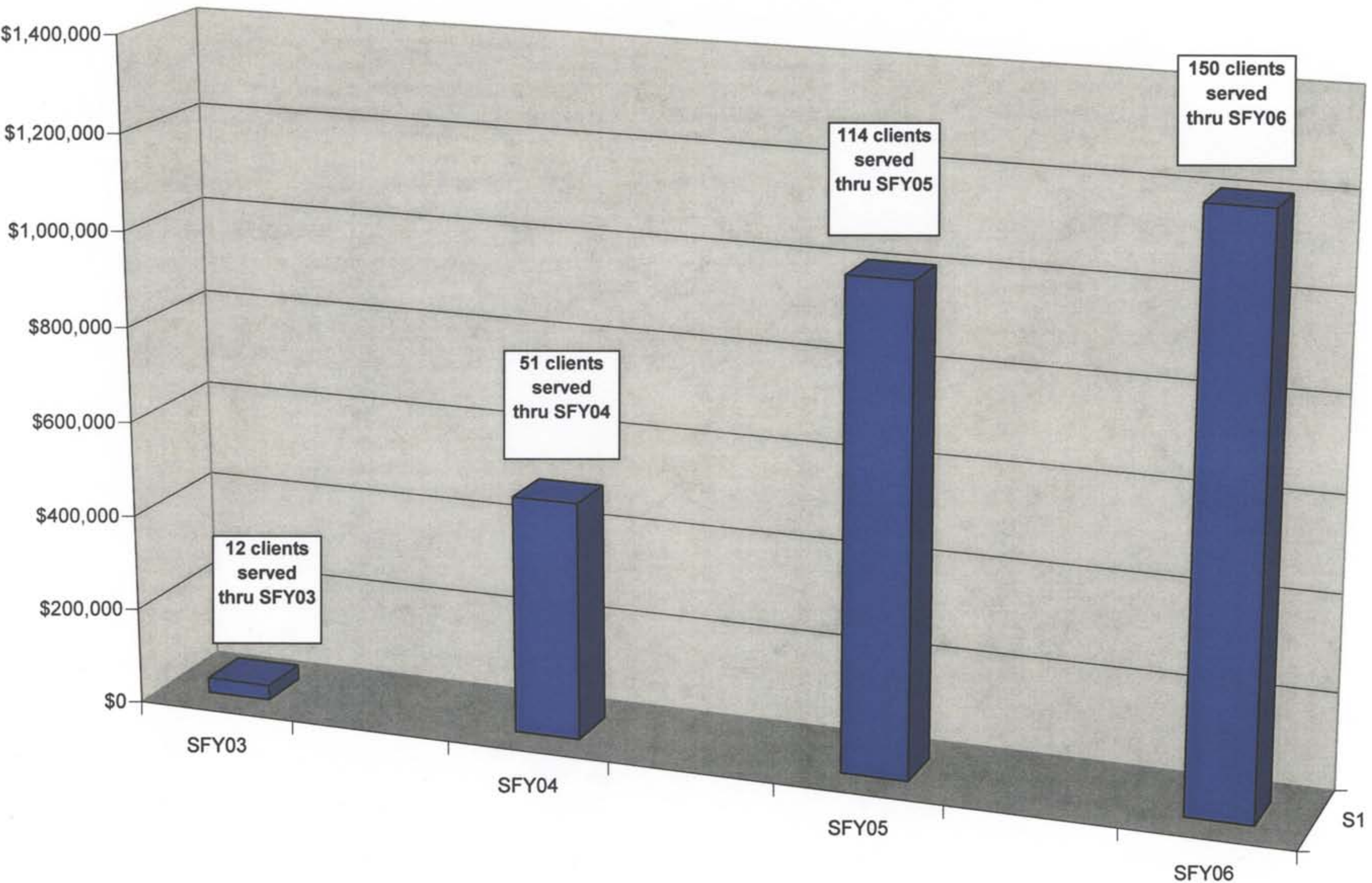
The Connecticut Home Care Program for Elders began offering Assisted Living Services in State Funded Congregate housing facilities in March 2001.

APPENDIX J



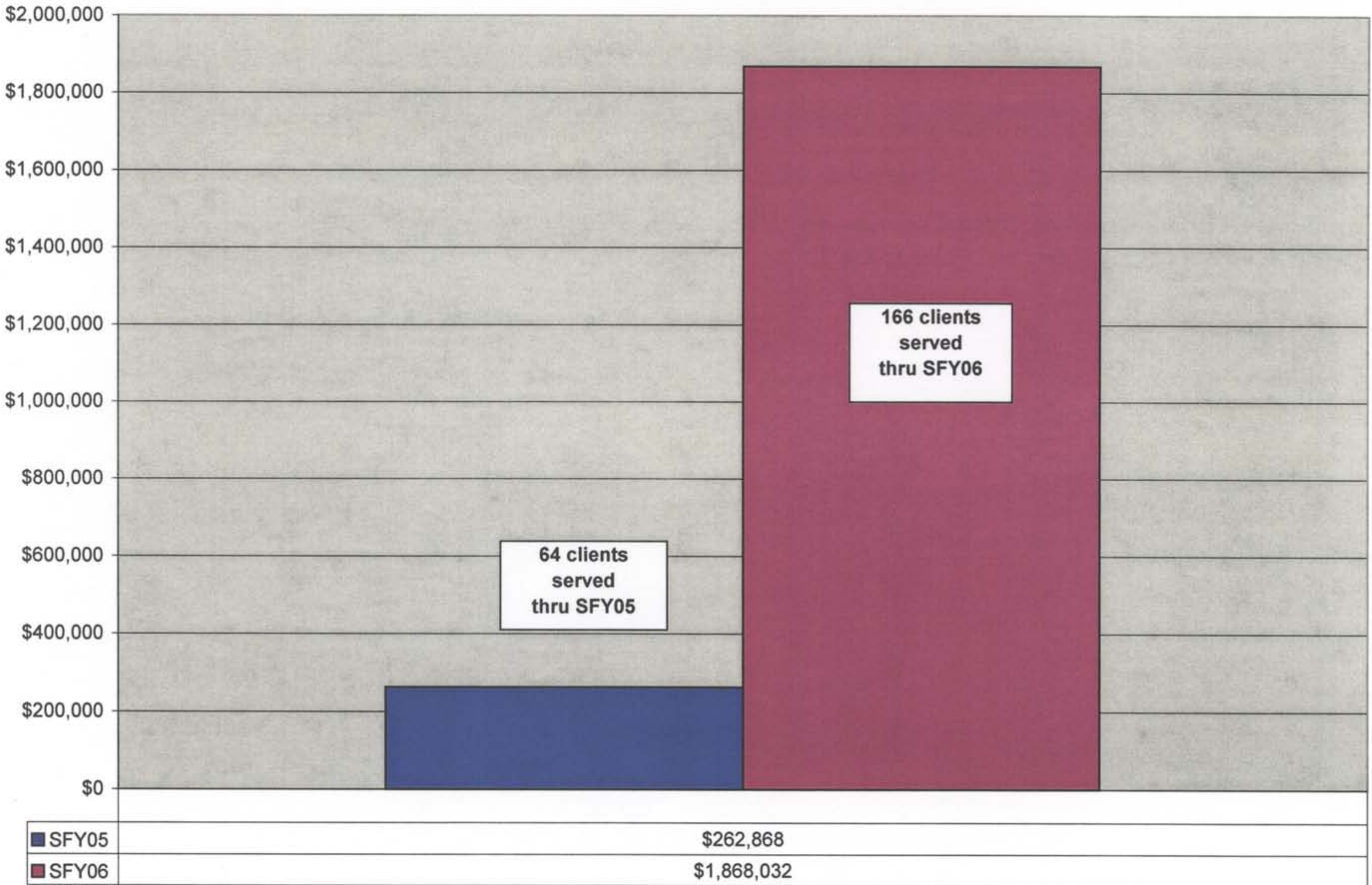
The Connecticut Home Care Program for Elders began offering Assisted Living Services in federally funded HUD facilities in March 2001.

APPENDIX K



The Private Assisted Living Pilot began in March 2003.

APPENDIX L



The first units under the demonstration project became occupied in September 2004.