Northeastern Vermont Regional Hospital Grant #03410-1562-16

VHCIP SUB GRANT

FINAL REPORT

Caledonia and s. Essex Duals project

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Table of Contents

Acknowledgments
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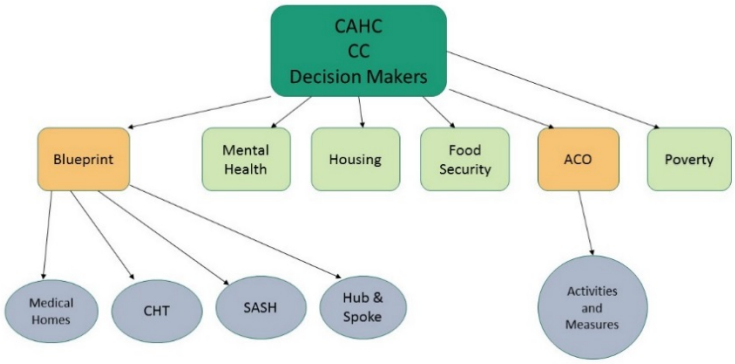
Executive Summary

When the VHCIP sub-grants were announced in 2014, the leadership team in our hospital service area (subsequently named Caledonia and s. Essex Accountable Health Community - CAHC) was still in its early stages of forming. This group doubles as the Community Collaborative (CC) for the Vermont Blueprint for Health and the Vermont ACO's.

FIGURE 1. Summary of Structure and Role of the CAHC



The leadership team of CAHC made up of executive directors and CEO's from the hospital, FQHC organization/home health and hospice, designated community mental health agency, designated regional housing organization, and the council on aging felt a project focused on the "dually eligible" population – those eligible for both Medicare and Medicaid, often perceived as some of the most vulnerable people in our area, was a good fit for the intentions/goals/objectives of the VHCIP sub-grant program.

After reviewing the data, including how many dually eligible reside in our area and the utilization of healthcare services from this group, the leadership team submitted a grant application with the following scope of work:

1. Employ a Health Coach to work with clients to improve their chronic disease self-management skills: conduct health assessments; reinforce provider-initiated treatment plans; provide hands-on assistance in support of chronic disease self-management plans; provide cooking lessons; and teach stress management and coping techniques.
2. Employ a Community Health Team (CHT) Coordinator to serve as overall project coordinator and work with Health Coach to identify and assess clients.
3. Develop data-sharing agreement between Sub recipient and the State regarding data sharing of expenditures for the dually eligible persons in the served area to compare past and current expenditures. Data will be used to identify at risk individuals and request referrals from primary care providers and CHT members.
4. Hold Dual Eligible Core Team (Duals Team) meetings on a semi-monthly basis to:
    a. Discuss individuals' services and situations to solve issues;

b. Evaluate current support structure, including existing care managers;
c. Designate the lead case manager for each individual if there is not one in place;
d. Determine needs for flexible funding;
e. Discuss and develop innovative solutions for individual problems;
f. Work with the patient to set self-management goals health and wellness;
g. Modify existing assessments if necessary to assure comprehensive assessments;
h. Develop client information protocols to ensure smooth transitions of care.
i. The team shall include: CHT coordinator; medical home care coordinators; medical home behavioral health specialist; case managers; Choices for Care case manager; community health workers from Community Connections; the patient and family or support persons; and additional CHT members as necessary.

5. Identify system issues that affect dually eligible persons that are beyond the scope of this project.

Shortly after receipt of this grant, we were fortunate to be invited to participate in the first cohort of communities of the VCHIP Care Models Care Management Learning Collaborative.

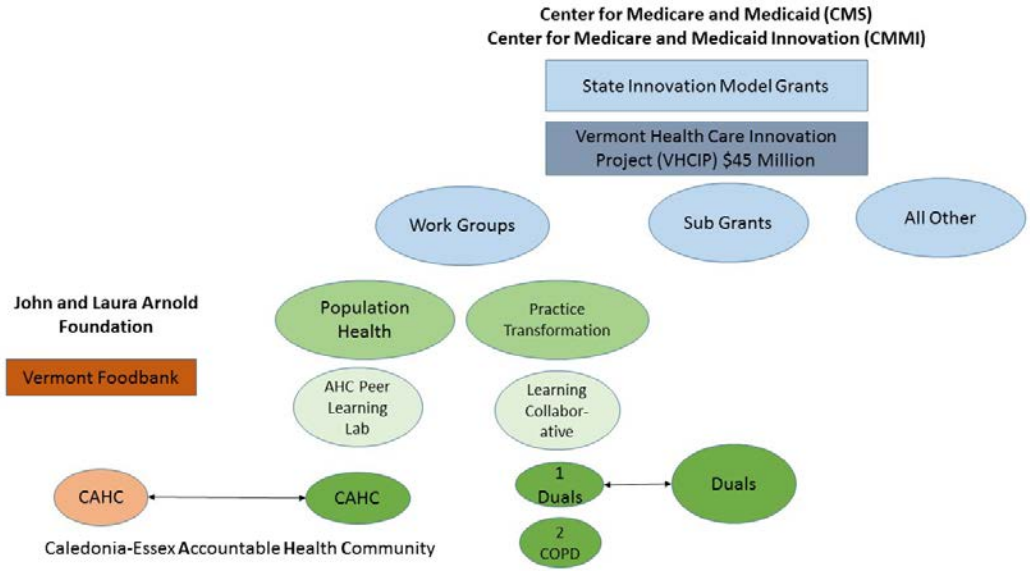
The Aim of the CMCM Learning Collaborative was *to develop and/or enhance integrated and collaborative care management, beginning with at-risk populations in the near term and expanding to the entire population over the longer term.*

A *subset* of the dually eligible populations was a natural choice for the Learning Collaborative. The goals of the Learning Collaborative were rolled into our larger sub-grant project:

- Identify dually eligible individuals at risk of harm, unnecessary nursing home stays or hospitalization
- Assign the individuals to a community interdisciplinary team
- Assign a lead case manager to be the primary contact with the individual and their support network
- Use a comprehensive assessment and care planning process to identify individual strengths and needs
- Develop a comprehensive person-centered plan of services

The two VHCIP projects (sub-grant and learning collaborative) were so closely aligned and intertwined it is impossible to separate the two.

FIGURE 2. Relationship of CAHC and VHCIP Projects



Discussion

Project Description:

What goals did you set for this project?

- Reduction in overall healthcare costs
- More efficient use of Medicaid Special Services
- Improved well-being of clients

How well do you think the project met these goals? What happened during your project? Do you have any stories that capture the impact of this project?

There is a discussion of how well we met our project goals in the evaluation and conclusion sections of this report. Briefly, we believe our project accomplished 2 out of 3 goals:

- More efficient use of Medicaid Special Services (some evidence from pre and post analysis by DVHA)
- Improved well-being of clients (see case studies)

The third goal - Reduction in overall healthcare costs is difficult to quantify in the short term with limited access to claims data.

As important, this project further strengthened our foundation of strong regional partnerships and care coordination processes – both essential as we move into this next uncertain phase of health care reform in Vermont.

Three cases studies that illustrate the team collaboration and improvement in person quality of life are included as an appendix to this report.

As outlined in the grant deliverables, the Dual Eligible Core Team (Duals Team) met on a semi-monthly basis to discuss individuals' services and situations to solve issues; evaluate current support structure, including existing care managers; designate the lead case manager for each individual if there is not one in place; determine needs for flexible funding; discuss and develop innovative solutions for individual problems; work with the patient to set self-management goals health and wellness; modify existing assessments if necessary to assure comprehensive assessments; develop client information protocols to ensure smooth transitions of care.

The team included: Co-chairs, medical home care coordinators; medical home behavioral health specialist; SASH Coordinators; Choices for Care case manager; community health workers from Community Connections; representatives from Council on Aging and Northeast Kingdom Human Services (mental health). The patient and family or support persons, and additional CHT members attended as necessary.

Did the project encounter internal or external challenges? How were they addressed? Was there something VHCIP could have done to assist you? Describe each challenge and the actions you undertook to address it. What was the effect on the project? If a change negatively affected the project, how did you attempt to cope with it?

The biggest challenge to the work was the limited capacity (resources) of some partner organizations. For example, the grant supplied flexible funding to do home renovations to help keep people in their homes e.g. handicapped accessible ramps or bathroom modifications; however, Vermont Center for Independent Living (VCIL), the obvious partner for this type of project (they have vetted contactors), still required long wait times for projects. The good news is that we were able to find a new partner – Habitat for Humanity – to get the work done in a timely fashion.

We also encountered long wait lists for housing for people with special needs. And encountered eligibility issues for Medicaid Special Services. For example, if a client has a vehicle registered in his/her name, this client is not eligible for Medicaid's public transportation benefit – even if the vehicle is not in good running condition. Also, although dually eligible people have Medicaid, they are not eligible for case management services under Vermont Chronic Care Initiative (VCCI).

Another big challenge was sharing information between partners in this care coordination project. Most organizations/agencies have their own (and unique) set of requirements making a universal waiver difficult to develop. We were fortunate to get some guidance from Gabe Epstein from DAIL; however, this is one area where a state-wide universal waiver would help.

Sharing information – such as a shared care plan - electronically between organizations is still not possible. We resorted to secure fax or hand delivery – not very efficient, but more or less effective. This is another area where a state-wide solution would help.

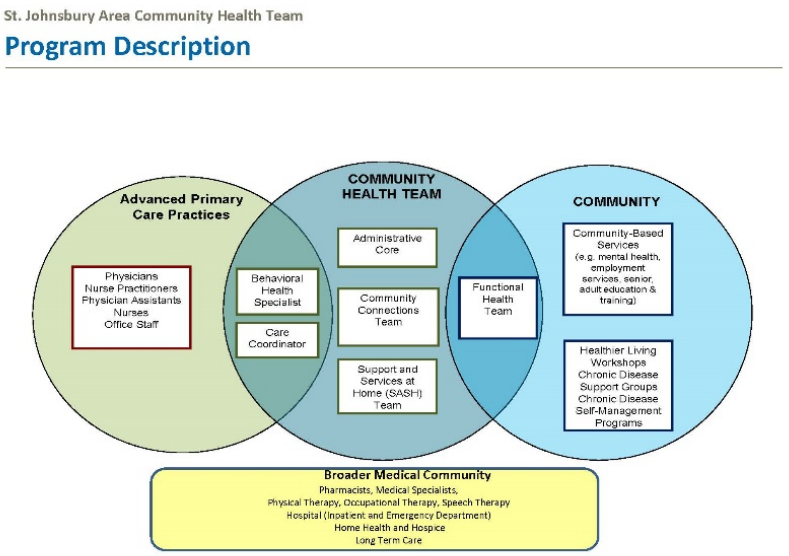
There were also some challenges to the evaluation component of the grant requirements. We submitted a request for technical assistance – attached as an appendix. More on this in the evaluation section of this report.

When considering the design and implementation of this project, what lessons did you learn that might help others implement similar changes? Please do not discuss specific findings or results of the project. Instead consider your process of implementing and executing this project, including, for example:

- *What steps you took during the planning stages to:*
  - *involve key stakeholders; and*
  - *allow for changes in key objectives in response to changes "on the ground."*
- *What elements of your implementation strategy worked, or did not work, and why?*
- *Is there anything you would do differently? If so, what?*

We purposely built this project on the existing Community Health Team (CHT) with Community Connections as the backbone program. Built on trust and strong partnerships, the CHT is robust and has been functioning well for many years. The CHT lead, Pam Smart was tapped as co-chair for this project because of her ability to pull together care coordination teams, and her clinical background in nursing. Treny Burgess, Director of Caledonia Home Health and Hospice was a natural choice to co-chair with Pam. Treny brought a wealth of knowledge and experience on care transition and the Choices for Care program, as well as process improvement skills. We also asked Laura Rooker, NVRH Physician Practice Operations Manager, to aid in data collection and process improvement components of the work. None of these key people were paid by the grant.

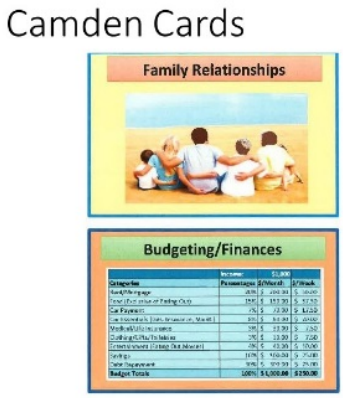
FIGURE 3 St Johnsbury Area Community Health Team



Hiring the right people is key to the success of any project. Lew Apgar was hired as the Health Coach. Lew has a background in EMS and a personal and professional interest in wellness. Lew is proficient in motivational interview and uses evidence-based tools for patient engagement and self-management. Lew also knows the community well and is comfortable meeting people in their homes or in the community. Lew joined the other community health workers in Community Connections and quickly jumped into the role as the "Duals guy". Lew became certified as a Tobacco Cessation Counselor and as a Stanford Chronic Pain Self-Management program leader while in this role. He helps his clients quit smoking, takes them grocery shopping, walks with them on their property or on the Lamoille Valley Rail Trail, and brings them fresh vegetables from the Vermont Foodbank's Veggie Van Go program.

Participating in the VHCIP CMCM Learning Collaborative profoundly helped move this project and our care coordination work forward. We were introduced to new patient engagement tools – Camden Cards, eco-maps – and were prompted to develop systems to identify a lead coordinator and create and share care plans. These are tools and systems that we have already "hardwired" into our care coordination practices in the region.

FIGURE 4 Sample Camden Cards and Domains of Health and Social Determinants



- Health Education & Management
- Housing Assistance
- Mental Health
- Addictions
- Education
- Health Insurance
- Utilities
- Medication & Supplies
- Legal
- Family Relationships
- Relationship & Safety
- Budgeting/Finances
- Food & Nutrition
- Transportation
- Wild Card

It took several months to develop a good system to distribute and account for the flexible funds. Several of our partners in this project were tentative about asking for funds (not sure why – they often forgot the funds were available or forgot what they were to be used for), and invoices were also not always easy to get from local vendors, especially for low cost items. We developed a check request system that included documentation from the person/agency making the request for funds. The check request included the name, date of birth, and specific reason the person needed the funds e.g. often a medical reason. A note from the patient's medical provider was also required; the request for funds needed to include a justified unmet medical need. This process facilitated communication between the provider, the patient, and the agency requesting the funds. We also developed a system of financial checks and balances (reconciling a spreadsheet to a general ledger) to insure accurate accounting of the flexible funds.

If we were to do this again, we would develop (or find) a standard assessment of complexity to better triage clients based on need. There was a very wide variety of need in our dually eligible clients; from a simple one-time intervention to those with ever increasing complex needs. It was a surprise to discover how many medically or socially complex people did not already have case managers. Because of the wide variety of needs with the duals, we also believe it may have been more effective to choose a population of people with similar needs for this project. That is why we have chosen to continue this "project" (without funding) working with people with COPD regardless of type of insurance coverage. (COPD has been identified as one of our top reasons for hospitalizations, re-admissions, ER visits, and home health visits.)

Evaluation:
Please report results for the indicators recently circulated to you for validation. Along with final metric results, please also include: data sources, how data was collected, methods used for data analysis and any known limitations that should be considered when reviewing your results.
Note: please err on the side of inclusion when deciding what numbers to present. Feel free to use tables or appendices. Please do not include graphs with no numbers, unless reference tables are included.

- *Please provide meaningful interpretation of the results, assess program/initiative success and draw any conclusions. This should include how results point to areas that deserve further inquiry and/or results that point to next steps.*
- *As relevant, please describe any geographical, socio-economic, political, environmental and historical context or setting influences that are unique to your program/grant, and that you suspect have influenced results as presented?*
- *What plans do you have (if any) for disseminating results?*
- *What additional impacts do you think the project has had? For example:*
  - *Has it created a new model for delivering services or conducting research?*
  - *Has it informed public policy? How?*
  - *Has it informed the work of other professionals or organizations? How?*
  - *Has it changed your organization so that it is better able to fulfill its mission? How?*

Case studies have been included in the Appendix and are submitted as part of the evaluation of this project. The case studies illustrate 2 things:

- How well the partners work together to coordinate care
- Accomplishment of Goal #3 of this project: improve well-being

As mentioned, technical assistance was requested from VHCIP for the evaluation of this project. It was not possible for VHCIP to provide resources for all the items requested. In the end, we were given access to Jim Westrich, an analyst from Department for Vermont Health Access, who looked at Medicaid spending – by category – pre and post/during intervention. Laural Ruggles sent a list of participants who received at least one of the interventions – either received flex funds or Health Coach services or both – to an analyst at the Department of Vermont Health Access (DVHA). The analyst looked at claims data for the "pre" intervention (July 2013 – June 2104), and "during" (July 2014 – December 2015) time periods. The results are summary in the tables and figures below.

TABLE 1: Results of Pre (July 2013 – June 2014) and Post/During (July 2014 – December 2015) analysis of Medicaid claims of clients receiving one or both project interventions.

	Paid Amount Per Member Year		
Categories of Service	**Pre**	**During**	**% Change**
HCBS	$ 5,126	$ 6,317	23.2%
Outpatient	$ 1,903	$ 1,937	1.8%
Clinics	$ 1,488	$ 1,661	11.6%
Other	$ 737	$ 864	17.3%
Nursing Home	$ 720	$ 718	-0.3%
Inpatient	$ 569	$ 480	-15.7%
Pharmacy	$ 560	$ 337	-39.8%
Supplies/DME	$ 480	$ 470	-2.0%
Physician	$ 436	$ 360	-17.5%
Personal Care Services	$ 391	$ 305	-22.0%
Day Treatment	$ 299	$ 366	22.3%
Home Health	$ 235	$ 342	45.2%
FQHC	$ 152	$ 114	-25.3%
Residential Treatment	$ 133	$ 152	14.1%
Dental	$ 120	$ 92	-23.2%
Rural Health	$ 89	$ 108	21.9%
Target Case Management	$ 78	$ 108	39.9%
Total	$13,514	$14,730	9.0%

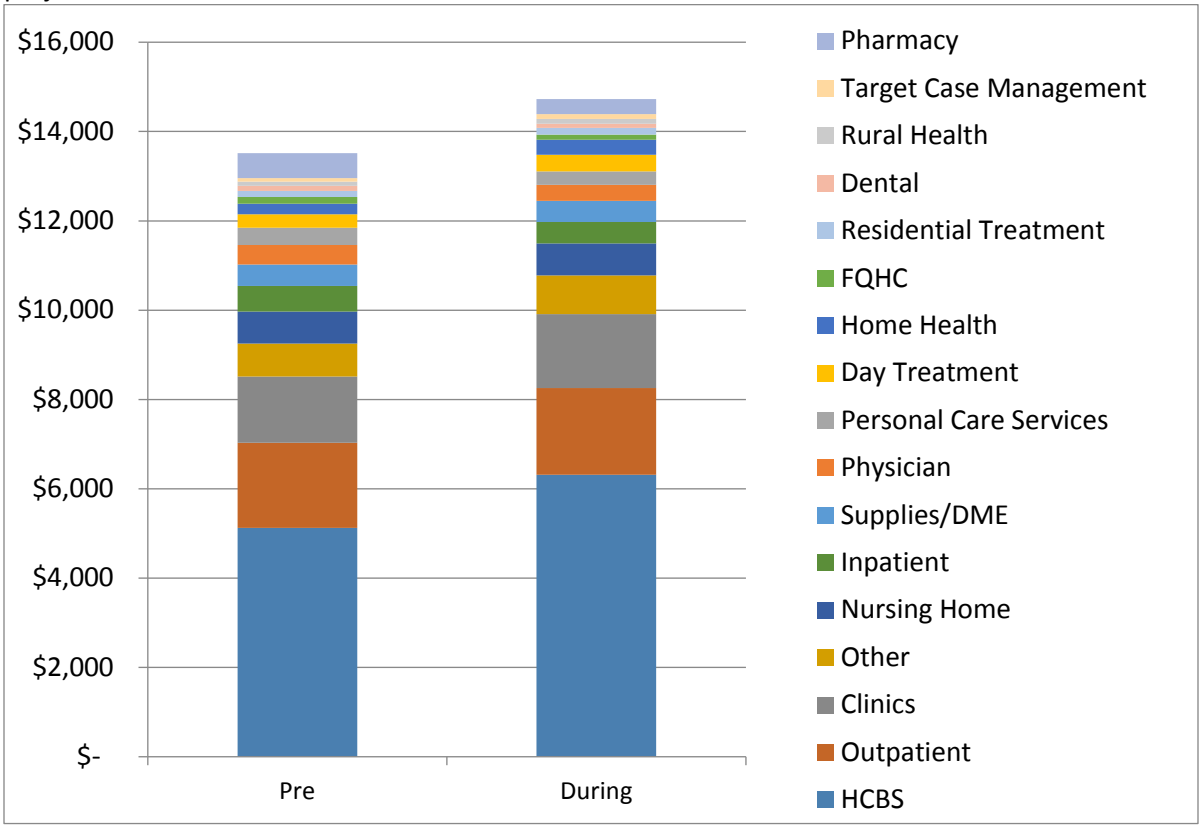
HCBS = Home and Community Based Services, Choices for Care
DME = Durable Medical Equipment
FQHC = Federally Qualified Health Center

Table 2 Analysis of Medicaid claims data for clients receiving one or both project interventions

	Pre	**During**	**% Change**
Admissions (per 100 Member Years)	30.7	38.2	24.6%
LOS for Admissions	10.7	9.0	-15.9%
Nursing Home Days per Member Year	3.0	2.4	-19.1%
Days with ED Visits per Member Year	1.9	2.2	15.3%

LOS = Length of stay
ED = Emergency department

Figure 5 Graphic depiction of Medicaid spending by category of service for clients receiving one or both project interventions



FQHC = Federally Qualified Health Center
DME = Durable Medical Equipment
HCBS = Home and Community Based Services, Choice for Care

It is important to note, that these are Medicaid spending only. The participants in this project have both Medicare and Medicaid. Medicare spending amounts is not readily available.

The results show an overall increase in health services during the intervention program. It is notable that the use of Choices for Care, Home Health, and targeted Case Management are all "positive" increases.

A de-identified listing of the uses and vendors for the flexible funds is included as an Appendix.

TABLE 3 Number of individuals receiving one or both project interventions

Health Coach Clients	80
Flexible Funds Clients	110

Updates on this project, while in progress, has been presented to the CAHC on a quarterly basis, several times to the CHT, and several times to various VHCIP workgroups. The results will be presented to the CAHC at the August meeting, and this report will be made available to all the partners in the project and anyone requesting it.

This project combined with the CMCM Learning Collaborative has helped advance care coordination in our region. Specifically, the process to identify a lead care coordinator, a more efficient waiver to share

information between care partners, the concept of a care plan – that will someday be able to be shared easily, and additional patient engagement tools (Camden Cards and eco-maps). This project strengthened existing partnership and helped form new ones e.g. Brain Injury Association of Vermont is now a key partner.

This project informed the work of all the participating organizations by improving trust issues around "funding". The team members have a better understanding of "who has funds for what" and we have a good process for sharing funds in a collaborative manner. The addition of the health coach furthered our mission to improve the health of the community by providing more resources for support, education, and care coordination and facilitation to access services.

Public policy issues identified by this project include:

- The need for a universal waiver form to allow more efficient sharing of information
- The need for an electronic solution for sharing a care plan
- The need for more flexible use of funds to cover quality of life essentials like financial help for housing, eye glasses, minor housing renovations, custom durable medical equipment not covered by Medicare or Medicare, fitness memberships.

Project Sustainability:

- *What are some effective ways to sustain or spread this project's work after VHCIP funding ends?*
- *What are the post-grant plans for the project if it does not conclude with the grant? Include a description of the following that are applicable:*
  - *Changes in operations and scope.*
  - *Replication or use of findings.*
  - *Names of other institutions you expect to involve.*
  - *Plans to support the project financially, including grants you are seeking or have received and/or a business plan to become self-supporting.*

As mentioned, many of the tools and processes learned from this project have already been hardwired into our care coordination work. We have spread the work to a new population of people – those with COPD. Lew, the Health Coach, has been hired permanently by NVRH as a community health worker in the Community Connections program. Lew will continue to work with "duals" and with people in need of his services regardless of insurance.

We hope new funding mechanisms in Vermont health reform will make our work a financial "no brainer", meaning there will be money to support staff and interventions that improve quality of life and health; and prevent, reduce or eliminate the need for people to access high cost health care.

Lead partners for this project are:

- NVRH (medical homes, emergency department, Community Connections, nutrition and diabetes counseling)
- Northern Counties Health Care (home health, Choices for Care, medical homes)
- Northeast Kingdom Mental Health
- Northeast Kingdom Council on Aging
- Rural Edge and SASH

Other CHT partners include: Northeast Kingdom Community Action, Brain Injury Association of Vermont, Vermont Department of Health, Vermont Department of Economic Services, Vermont Agency of Human Services, BAART, VCIL, Habitat for Humanity, VCCI, DAIL, St. Johnsbury Restorative Justice Center, Vermont Department of Corrections, Umbrella, Kingdom Recovery Center, St. Johnsbury Schools.

Conclusion

We believe our project accomplished 2 out of 3 goals:

- More efficient use of Medicaid Special Services (some evidence from pre and post analysis by DVHA)
- Improved well-being of clients (see case studies)

The third goal - Reduction in overall healthcare costs - is difficult to quantify in the short term with limited access to claims data.

We identified several benefits to the patients; they self-report increased satisfaction with quality of life and improved access to health care and mental health services.

As important, this project further strengthened our foundation of strong regional partnerships and care coordination processes, clarified the roles of partners, improved awareness and referrals to new (Brain Injury Association of Vermont, Habitat for Humanity) and existing partners. These strong partnerships are essential as we move into this next uncertain phase of health care reform in Vermont.

Appendix A
Case Studies

Patient Gender: Female	**Patient Age:** 78
Lead Care Coordinator Name: Lew Apgar/ Brandy Newland	Agency: Caledonia Home Health Care
Care Team: (name and agency) Brandy Newland, Caledonia Home Health Care. (Client was unable to meet with or speak to any DUAL coordinators because of her language barrier and anxiety.)	
Root Cause: Client could not get up the stairs that led to her bedroom and accessible bathroom due to severe arthritis to both knees and bakers cysts behind both knees.	
Patient medical and social conditions: Tell the story Client lives with her Daughter and Son in Law, speaks no English and suffers daily with severe physical and emotional pain. Client has severe post-traumatic stress disorder and severe arthritis and neuropathy caused by her Diabetes. Her medical diagnoses compromise both her physical and emotional independence. Any changes in her life can cause detrimental stress, anxiety, pain and decline.	
Patient Self-Management Goals: To remain as safe and independent as possible in her family's home.	
Services received: Through multiple funding efforts from local community resources and $1020.00 dollars from the dual funds, the client was able to have a stair lift installed in her home by Keene medical. The stair lifts cost about $3800.00 dollars and VCIL only has 1500 dollars of funding so it was very helpful to have the DUALS options for this client.	
Outcomes: Tell the Story The stair lift provided client with reduced stress, reduced pain, increased safety and security and the ability to keep her familiarity in her Daughters home. Client does not speak English but has learned to Say Thank you and will thank CM at every home visit for the stair lift.	

Patient Gender: M	**Patient Age:** 30
Lead Care Coordinator Name: Heidi Baker	**Agency:** NEK Council on Aging

Care Team: (name and agency)

Heidi Baker, Case Manager from NEK Council on Aging
Dr. Tanner, Primary Care Physician from Danville Health Center
Oxbow Senior Independence Program – Adult day services

Root Cause: Cause of patient's TBI and paralysis is bicycle accident from childhood.

Patient medical and social conditions: Tell the story

Patient was involved in serious bicycle accident when he was a child. As a result of the accident patient suffered from TBI and other severe medical issues, leaving him paralyzed. Patient is confined to wheelchair at all times and is completely dependent on others for ADL assistance. Patient is not able to communicate other than a simple hand motion for "yes" and "no." Patient had a recent decline and is now strictly tube fed.

Patient's diagnoses are TBI, Spastic Quadriplegic, Oral Motor Paralysis, Autonomic Dysregulation.

Patient Self-Management Goals: Patient goals are to maintain independence within the community.

Services received:

Patient receives home-based services from Choices for Care. Choices for Care provides assistance with personal care such as bathing, dressing, personal hygiene, etc. Patient also receives respite services from Choices for Care and attends the adult day center 3 days per week for socialization.

From the Duals Grant patient was able to purchase a new manual wheelchair. After several years of using old manual wheelchair, the chair was falling apart and very unsafe for the patient. While insurance covered the cost of a new power chair, the manual chair was not covered. Both the power chair and manual chair are critical for client, as he must be transported in the manual chair and can only attend the adult day center in his manual chair. Client's mother is his guardian and main caregiver and did not have the funds to purchase the manual wheelchair.

Outcomes: Tell the Story

With funds from the Dual's Grant, patient was able to purchase new manual wheelchair that fit him appropriately and was safe. Client now has access to medical appointments, transportation in his mother's van, and access to the local adult day center. Patient's body is supported and client is more comfortable. Because of his new manual wheelchair, patient and his mother are planning on attending a week long retreat together this summer. Patient has better access to the entire world around him, thanks to the funds he received from the Dual's Grant.

Patient Gender: Female	**Patient Age:** 36
Lead Care Coordinator Name: Peggy Hale	**Agency: Human Services**
Care Team: (name and agency) Bonnie- Human Services, Peggy Hale- Kingdom Internal, Ginny Flanders -NVRH dietician, Faith Voc. Rehab. Terri and Kate- Rural edge, Lew Apgar- NVRH Community Connections, Marek Pyka-human services	
Root Cause: Childhood trauma	
Patient medical and social conditions: When first introduced to client with severe eating disorder, MJT, PTSD, Chronic Pain, financial and legal problems, and borderline personality disorder; she was financially unsustainable, and in danger of losing her housing and vehicle. Client had been taken advantage of by a car dealership, which contributed to her stress and low self-worth. Client was working two volunteer positions that she thought of as jobs because they paid mileage. Eating disorder and stressors had this adult woman to 78lbs, and in constant risk of complications due to poor nutrition and purging.	
Patient Self-Management Goals: not purging and eating healthy so she can maintain career goals and becoming more financially stable.	
Services received: Transportation to treatment for eating disorder. Coordinated team meetings. Financial literacy and connection to other services. Creative problem solving for pets. Tobacco treatment. Client now knows which of her care team to go to with specific problems.	
Outcomes: Tell the Story: Although the client's vehicle was ultimately repossessed, client is now financially sustainable and at a new Job (2-weeks). She now learned to navigate public transportation systems. Client is more capable of prioritizing her expenses. Health and pain have improved. Client reports no purging. Client continues to work towards a healthy weight.	

Appendix B
Request for Technical Assistance

Northeastern Vermont Regional Hospital
VHCIP SubGrant Technical Assistance Request

Outcome	Population	Time Period	Reason	Possible Data Source
Fewer nursing home Days	Dual eligible (Medicare and Medicaid) in the NVRH service area*	Pre and during intervention. Pre: July 2013 – June 2014. During: July 2014 – December 2015	To document cost savings	DVHA claims
Fewer Incarcerations	Dual eligible (Medicare and Medicaid) in the NVRH service area*	Pre and during intervention. Pre: July 2013 – June 2014. During: July 2014 – December 2015	To document cost savings	Dept of Corrections
Reduction in homelessness	Dual eligible (Medicare and Medicaid) in the NVRH service area*	Pre and during intervention. Pre: July 2013 – June 2014. During: July 2014 – December 2015	To document social determinant of health improvement	Agency of Human Services
Improved customer satisfaction	Dual eligible (Medicare and Medicaid) in the NVRH service area*	Post intervention: January 2016	To document patient experience	Post intervention focus group
Improved well-being	Dual eligible (Medicare and Medicaid) in the NVRH service area*	Measured at start of the invention and ongoing	To document patient engagement	Community Connections assessment tool. Completed by Duals Health Coach only.

*These zip codes: 05819, 05828,05873,05821,05848,05824,05851,05832,05866,05867,05871,05858,05840,05837,05840,05906, 05905

Appendix C
Flexible Funds: Items, Vendors, Amount

Purchase	Vendor	Amount
CSA	Pete's Greens	$ 187.00
storm Door	Belknap	$ 489.12
weights	Olympia Sports	$ 63.58
mattress	Mayo's	$ 1,499.00
glasses	Eye Associates	$ 140.00
alarm clock	Radio Shack	$ 37.08
shower bench	Lincare	$ 81.39
labor	Harris Plumbing	$ 1,500.00
gym membership	RecFit	$ 68.90
gel, sheep skin	Keene Medical	$ 484.96
recliner	Mayo's	$ 495.00
glasses	Optical Expressions	$ 149.00
white task lamp	Full Spectrum	$ 313.64
personal trainer	Jeremiah Powell	$ 300.00
hospital bed	Lincare	$ 1,978.00
yoga session	Heart Space Yoga	$ 65.00
handicap equipment	Ride Away	$ 1,606.77
mattress	Modern Furniture	$ 808.94
bariatric bed	Keene Medical	$ 1,833.00
Bed Bar	CHHC	$ 111.20
membership	RecFit	$ 157.94
Massage	Body Charge	$ 20.00
emergency monitoring	NEERS	$ 480.00
electric bill	GMP	$ 1,953.70
microwave	Job Lot	$ 73.14
handicap equipment	Ride-Away	$ 475.00
men's knit pants	Job Lot	$ 8.00
electric recliner	Modern Furniture	$ 528.94
vitamins	Swanson Vitamins	$ 72.20
eye glasses lenses	Eye Associates	$ 119.00
stair lift	Keene Medical	$ 525.75
water softener	Harris Plumbing	$ 692.50
moving expenses	Gregory McKay	$ 250.00
personal trainer	Jeremiah Powell	$ 570.00
gym membership	RecFit	$ 85.86
eye glasses frames	Eye Associates	$ 138.00
personal trainer	Jeremiah Powell	$ 435.00

Medical Alert	Mobile Help	$	393.40
Recfit	RecFit	$	42.40
glasses	VT Eye Associates	$	330.00
fuel	Dead River	$	352.05
bed	Modern Furniture	$	770.00
wheelchair	Medical Store	$	6,714.00
dumbbells	Olympia Sports	$	69.92
phone bill	Fairpoint	$	50.98
ramp	Habitat for Humanity	$	667.33
ramp	Habitat for Humanity	$	2,900.00
air conditioner	Job Lots	$	189.74
lift repair	Ride Away	$	825.00
transport to hospital	John Irons	$	250.00
mattress	Mayo Furniture	$	350.00
personal trainer	Jeremiah Powell	$	435.00
phone alert	Lifeline	$	384.84
ramp	Habitat for Humanity	$	1,100.00
walker	Keene Medical	$	175.00
leg Lift	CHHC	$	16.00
personal trainer	Jeremiah Powell	$	435.00
bathroom modifications	Carter Contracting	$	6,060.60
mattress	Modern Furniture	$	498.00
running water	Carlson's Plumbing	$	1,924.84
telephone bill	AT&T	$	96.88
ramp	Habitat for Humanity	$	1,223.00
Meals on Wheels	MOW - St J	$	2,184.00
budgeting class	Rural Edge	$	35.00
Meals on Wheels	MOW - St J	$	500.00
Meals on Wheels	MOW - St J	$	500.00
transport to hospital	Jeannie Ayer	$	40.00
glasses	Eye Associates	$	110.00
hotel (for bed bug fumigation)	Colonnade Inn	$	495.00
eye glasses	Green Mtn Eye Care	$	359.00
cat treatment for bed bugs	Western Ave Vet Clinic	$	158.11
phone	Fairpoint	$	136.23
vehicle transport (bed bugs)	Roland’s Wrecker	$	85.00
transportation	Jeannie Ayer	$	73.00
foot care	Patricia Bergeron	$	25.00
eye glasses	Eye Associates	$	85.00
eye glasses	Optical Expressions	$	165.00
wood stove	Erik Armstrong	$	1,186.94

ramp	Habitat for Humanity	$ 1,100.00
ramp	T&B Contracting	$ 3,450.00
bathroom modifications (2 payment)	Carter Contracting	$ 3,886.71
food cards	White Market	$ 200.00
battery-wheel chair	Keene Medical	$ 399.50
personal trainer	Jeremiah Powell	$ 435.00
walker	Keene Medical	$ 220.60
replace fuel tank	Bourne Energy	$ 2,062.58
transportation	Exercise class - LSC	$ 105.00
walker, transfer bench	Keene Medical	$ 404.30
mattress for hospital bed	Keene Medical	$ 207.00
transportation	Jeannie Ayer	$ 30.00
home care	CHHC	$ 101.01
bathroom reno	Travis Fraser	$ 750.00
wheelchair (balance due)	Yankee Medical	$ 2,151.00
mattress	Mayo Furniture	$ 650.00
mattress	Mayo Furniture	$ 655.00
taxi	John Irons	$ 20.00
taxi	John Irons	$ 50.00
custom circaids	The Medical Store	$ 2,690.00
car repairs	Vianor	$ 822.00
rent	Rural Edge	$ 197.00
grocery gift card	Price Chopper	$ 400.00
light therapy	Full Spectrum	$ 139.00
treadmill	Sears	$ 673.00
day services	Riverside Life Enrichment	$ 5,000.00
pool membership	Comfort Inn	$ 360.00
over bed table	Lincare	$ 138.00
transportation	John Irons	$ 10.00
fitness club	RecFit	$ 105.00
lift (cost split with VCIL)	Sterling Handyman	$ 7,300.00
septic pumping	B&B Septic	$ 335.00
gas card to medical appt	Sunoco	$ 50.00
bathroom modifications	Sterling Handyman	$ 490.00
rent	Rural Edge	$ 732.50
blood pressure cuff	Keene Medical	$ 100.40
lift chair	Keene Medical	$ 790.00
blood pressure cuff	Rite Aid	$ 36.89
move to safe housing	Dollar Store	$ 18.02
move to safe housing	Job Lot	$ 103.93
IPad	Amazon	$ 346.19

co-pay	Kinney's	$	98.00
home care	Susie Greave	$	2,100.00
home care	Susie Greaves	$	750.00
eye glasses	Eye Associates	$	110.00
Lift chair	Keene Medical	$	710.00
exercise program	RecFit	$	74.20
Glasses	Optical Expressions	$	308.00
housing security	RuralEdge	$	650.00
transportation to UVMMC	RCT	$	183.08
glucose monitor	Dexcom Inc	$	204.00
emergency monitoring	Mobile Help	$	359.40
pill dispenser and cordless phone	Amazon	$	132.40
		$	**94,581.58**