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Promoting Integrated Community Living in Family Care, Partnership and PACE

Purpose:

A primary goal of the Family Care, Partnership and PACE programs is to ensure that members receive highly individualized, cost-effective long-term care services while living in an integrated living arrangement consistent with their identified outcomes. This document outlines procedures designed to ensure that MCO interdisciplinary care teams give careful consideration to the choice and authorization of integrated community living arrangements for every member.

Background:

Improving members' quality of life by strengthening and supporting their relationships and connections with their families, neighborhoods and communities is a primary purpose of Family Care. Supporting long-term, committed relationships between members and their family, friends, and wider communities is critical to supporting members' identified outcomes, including health and safety. Family Care seeks ways to strengthen and augment those invaluable relationships through their inclusion in member-centered assessment and care planning processes.

The Department of Health Services (DHS) considers the member's natural living setting as a home, owned by the member or the member's family, or apartment leased/rented by the member or the member's family, as the most integrated living arrangement available to program participants. Most of us have a strong preference to live in our own home and among family and friends because it best allows us to maintain family, religious, employment and other social connections to our community. Developing and maintaining similar community connections for Family Care members has been identified as a key to high quality long-term care programs.

Alternate residential settings, including Adult Family Homes, Community-Based Residential Settings, and Residential Care Apartment Complexes are a necessary and vital part of the provider networks available to members. There are situations in which living in a residential care setting is necessary and the most appropriate setting for health and safety, and/or is the most cost-effective setting for the care the member requires. When a member lives in a residential setting, it is essential to support opportunities for the member to maintain community connections and to exercise independence over daily routines and interactions.

If someone is already a resident of a nursing home or residential facility when they enroll in Family Care, then the interdisciplinary team staff (IDT staff) should follow this guideline to assess whether the current setting is the most integrated setting appropriate for the needs of the

new member, and if it is a cost-effective option for meeting that member's needs and supporting their long-term care outcomes.

The talking points in Attachment B to this memorandum should be useful to MCOs in implementing these guidelines and explaining program policy to members and their representatives.

Policy:

Assisting members to attain or maintain optimal independence and to keep family and community connections has always been at the heart and a core value of the Family Care, Partnership and PACE programs. Integrated community living remains a core value, and is not a new direction for Wisconsin's long-term care programs.

Family Care, Partnership, and PACE are committed to first providing long-term care services to participants in their own homes and apartments, and to support members' independence in these natural living settings.

For members currently in a natural living setting, a residential setting is authorized only when members' long-term care outcomes cannot be effectively and cost-effectively supported in natural living settings, or when members' health and safety cannot be adequately safeguarded, and when it is an effective and cost-effective option for that member's long-term care needs.

When a member or their representative expresses interest in or requests a residential setting, the IDT staff should explore needs or outcomes that the member thinks a residential setting will support, and discuss with the member other possible ways to support those needs and outcomes in a natural setting. The member's preferences should always be treated respectfully. IDTs should continually assess members' ability to remain safely in natural living settings, or to return to natural living settings. All supports in a home environment or an apartment setting or any other lesser-restrictive setting should be considered prior to a residential placement.

Definitions:

Cost-effective is defined as effectively supporting an identified long-term care outcome at a reasonable cost and effort.

Integrated community living is defined as full participation in community life. The U.S. Department of Health and Human Services, Administration for Community Living (ACL) states, "All Americans – including people with disabilities and seniors – should be able to live at home with the supports they need, participating in communities that value their contributions."

Interdisciplinary Team (IDT) means the member and individuals identified by the MCO to provide care management services to members.

Interdisciplinary Team Staff (IDT Staff) means individual employees assigned to an IDT that have specialized knowledge of the conditions of the target populations served by the MCO, the full-range of long-term care resources and community alternatives.

Long-Term Care Outcomes (LTC Outcomes) means a situation, condition or circumstance, that a member or IDT staff member identifies that maximizes a member's highest level of independence. A long-term care outcome is based on the member's identified clinical and functional needs.

- *Clinical Outcomes* means a condition or circumstance that relates to a member's individual physical, mental, or emotional health, safety, or well-being. Clinical outcomes are objectively measurable by someone other than the member, and their presence or absence can be determined without knowing the member's preferences regarding the condition or circumstance.

- *Functional Outcomes* means an ability that the member has to perform certain functions, tasks, or activities. The presence, absence, or degree of functional outcomes can be objectively measurable by someone other than the member, and can be determined without knowing the member's preferences regarding the functional ability.

Personal Experience Outcomes means a desirable situation, condition or circumstance that a member identifies as important to him or her**.**

Natural living setting is defined as a home, owned by the member or the member's family, or apartment leased/rented by the member or the member's family. The member may be living with their spouse or significant, other family members other or a roommate of their choice.

Natural support is defined as individuals and resources an individual or family can access "naturally," independent from formal services. These supports can include people such as extended family, friends, mentors, volunteers, church members and people met through community activities. Natural supports can also be resources found in the community such as libraries, clubs, memberships, senior centers, local events, or classes and activities at local community centers.

Residential settings include Adult Family Homes, Community-Based Residential Settings, and Residential Care Apartment Complexes. Definitions of these settings is included as Attachment A.

Implementation of This Policy:
Implementation of this policy is part of the basic cycle of assessment, care planning and ongoing care management. MCOs have flexibility to implement this policy in conjunction with their own policies and procedures; there is not an expectation that this policy be implemented separate from existing procedures or guidance. It is expected that the overall approach and philosophy is clearly implemented in each MCOs' procedures.

I. Procedures

A. The initial and ongoing member-centered strengths-based comprehensive **assessment** is the keystone to identifying and supporting member outcomes.

In order to assure that every effort is made to support members in natural living settings, IDTs will use the guidelines in this document in completing each member's initial and ongoing comprehensive assessment and in assuring complete assessment of current community connections and natural supports, and of opportunities for enhancing and increasing the member's circle of support from family, friends, and the community.

B. The member's individualized care plan identifies how the member's long-term care needs and outcomes will be supported.

For each member, IDTs will develop a plan to support optimal integrated community living designed to support the member to live in their natural living setting.

- For a young adult transitioning from school, the plan to support optimal integrated community living will be a plan for **achieving** optimal independence and will focus on developing the skills, opportunities for income generation and other resources the member will need to eventually leave his/her family home. While he/she continues to live in the family home, the care plan will address how supports to participate in meaningful activities including employment and other community activities will be provided. There may be situations in which staying in the parents / family home inhibits achieving independence; the IDT, which includes the member and his/her representatives, should determine the most effective setting for the young member to achieve optimal independence over time. In all situations, there should be clear goals and documentation of the steps to achieve increased independence and opportunities for community integration.

- For a frail elder or an adult who is disabled as a result of accident or illness, the plan to support integrated community living will be a plan for **restoring and preserving** optimal independence and will focus on rehabilitation, prevention, and developing new skills for coping with declining health and abilities and for maintaining ties to the member's family, friends, and other community connections. The plan will sustain the member and his/her natural supports in the effort to continue to live in the member's home, or with family or friends. The care plan will address how supports to participate in meaningful activities including employment and other community activities will be provided. Prior to authorizing/reauthorizing residential services for a member (based on utilization of the Guidelines discussed below), IDTs will either:

    1. Determine that the plan to support optimal integrated community living is not effective in meeting the member's

needs and supporting the member's long-term care outcomes, including personal experience outcomes; or

2. Determine that the residential setting would be more cost-effective in meeting the member's needs and supporting the member's long-term care outcomes.

DHS encourages MCOs to include procedures that make additional expertise available to assist IDTs to determine how community living could be workable for the member. If choosing residential services is most appropriate to the member's needs, then a residential setting should be as non-restricted as possible. Such additional expertise may be in the form of internal MCO experts, or through other means.

C. IDT staff provide ongoing care management to support members to maintain health, optimal independence and quality of life. Quality care management can be a means of preventive care. Examples include recognizing a member's need for meaningful activity and supporting that need, intervening to treat depression, and recognizing and responding to a member's needs when grieving a loss of spouse or other loved one or important relationship.

For each member, IDT staff will provide quality ongoing care management – both clinical and psychosocial – as a means of preventing the need for a residential setting.

When residential services are authorized for a member, interdisciplinary teams will provide quality ongoing care management – both clinical and psychosocial – to assure that the member is doing well in the residential setting and to monitor the member's situation for any potential to return to a natural living setting.

II. Guidelines for Members Living in Natural Settings:

IDTs will use the following guidelines to assure the use of all appropriate resources to effectively support people to remain in their natural settings. These guidelines are consistent with the MCO's comprehensive assessment and re-assessment, so these guidelines may be considered as a "check-back" for thoroughness, to make sure the IDT addressed the priority considerations in each of the needs areas. The assessment criteria identified below are those which might likely indicate a need for a more supportive living setting, and which may be effectively remediated so that the individual can continue to live safely in a natural setting.

IDTs may focus on groups of members that the MCOs utilization review process has identified as being over served in residential settings, as compared to statewide program norms. This may include members who are medically frail and/or have significant physical, cognitive and/or mental health care needs which require substantial hands-on overnight care or supervision on a long-term basis. MCO utilization review processes may identify groups of members with services

or costs outside of the norm; however, care planning is always done on an individualized and person-centered basis.

A. Thoroughly **investigate, and to the extent possible remediate, any underlying conditions** that result in the member's functional or health-related needs in order to maximize the member's ability to live in a natural setting.

1. Address **physical health needs**. Situations which may pose challenges to living in natural settings include:

   a. Recent hospitalization(s) or re-hospitalizations, which may be addressed by better transition planning.
   b. Decline in Activities of Daily Living (ADL) status for critical ADLs that must occur more than twice a day, such as toileting, feeding, or transferring, and for which adequate natural supports are not available.
   c. Incontinence, which may be able to be remediated through appropriate diagnosis and treatment, and may be managed in natural settings with appropriate supports.
   d. Need for multiple medications several times per day, which may be supported through use of medication dispensing devices or consultation with health care provider to review medication schedule.
   e. Frequent falls (i.e., more than one fall/month), which may be addressed through evidence-based falls prevention programs.
   f. Adequate nutrition, which may be address through home-delivered meals.
   g. Skin integrity, such as a change in wound status, new onset or worsening of a current wound.
   h. An increase or decrease in known behaviors of the individual; or new onset or change in a behavior that would trigger evaluation for potential medical, mental health or medication review.

   The IDT should ensure that people with deteriorating health conditions have received appropriate evaluations and medical care to remediate these conditions and maintain independent functioning to the extent possible.

2. Address any **mental health and substance abuse** issues. Some situations which pose challenges to living in natural settings include:

   a. Changes in mental health, which should be addressed by re-assessing the mental health needs and related supports.
   b. Unstable, chronic mental health needs.
   c. Unstable substance abuse issues.
   d. Unresolved grief or depression.
   e. Lack of meaningful relationships and/or activities.
   f. Behavioral issues that could be managed with a behavioral care plan, behavioral support plan, or communication plan.

3. Address **needs related to cognitive status**. Situations that may need attention to maintain living in natural settings include:

    a. Progressive changes in cognition, such as a new onset or increase in cognitive symptoms of impairment, confusion or forgetfulness.
    b. Changes in member coping mechanism, ability to filter distractions or information appropriately, acting out behaviors or isolation/and withdrawal type behaviors.
    c. Self-neglect.
    d. Difficulties with financial management and maintenance of eligibility.

    Prevention and interventions for changing cognitive status may include early, screening and thorough assessment for Alzheimer's disease and related dementias and memory loss. Referral to memory clinics for treatment may prolong the time member can remain safe in their natural setting. The IDT should ensure that people with reversible causes of dementia or deteriorating health conditions have received appropriate evaluations and medical care.

4. Thoroughly assess and support the member's community and natural support network, including investigating and implementing efforts to expand the community supports available to the member. Situations that may make it more difficult for people to remain in natural settings include:

    a. Changes or anticipated changes in natural support system, such as loss of spouse.
    b. Living alone.
    c. Living alone with no or few family or community supports.
    d. Change in caregiver status/caregiver burnout.
    e. Self-neglect/financial exploitation/elder abuse issues.

    The IDT should routinely reassess caregivers' status and stress and provide supports, as appropriate, including respite, education about the member's condition and care needs, and understanding of the progression of a condition and other ways to reduce stress and support the caregiver. The IDT should also work to prevent financial exploitation and, as appropriate, help arrange for formal and legal arrangements to assure security of the member's income and assets.

5. Maximize Community Services. Prior to considering permanent residential placement as an option, ensure current member-centered plan effectively utilizes available community supports, both natural supports and those available from MCO providers. Consider member preferences and outcomes throughout the process.

6. Assess the need for and, as appropriate, provide environmental, technological, and other interventions to support the member in a natural setting. All reasonable environmental safety actions have been considered (e.g., actions that promote fire safety) prior to a more restrictive placement.

III. Procedure for Individuals living in Residential Settings when Enrolled in Family Care, Family Care Partnership, or PACE.

IDTs should work with members already living in residential settings with the same goals as those for people currently living in their own homes or with family, to offer them cost-effective options for supporting their health and long-term care needs and supporting their personal experience outcomes. The residential setting should not be presumed to be the most appropriate setting for that member and the team should proceed with the assessment and care planning to assure the person is living in the most integrated and cost-effective setting available that supports the member's long-term care outcomes, including personal experience outcomes.

When a member or their representative wants the person to remain in an alternate residential setting, the IDT should explore the needs or outcomes the member thinks that the residential services are effective at supporting, and discuss with the member other possible ways to support those needs and outcomes in a natural setting. The member's preferences should always be treated respectfully. IDTs should continually assess members' ability to safely return to natural living settings. All supports in a home environment, apartment setting or any other more independent and integrated setting should be considered as alternatives to the current residential placement.

Attachments:
Definitions of Residential Settings
Talking Points about Residential Services in Managed Long-Term Care

Attachment A – Definitions of Residential Settings

a. Adult Family Homes of 1-2 beds are places in which the operator provides care, treatment, support, or services above the level of room and board to up to two adults. Services typically include supportive home care, personal care and supervision. Services may also include transportation and recreational/social activities, behavior and social supports, daily living skills training and transportation if provided by the operator or designee of the operator. Includes homes which are the primary domicile of the operator or homes where staff are hired by a third party who also controls the place. Adult family home services also include coordination with other services received by the member and providers, including health care services, vocational or day services.

b. Adult Family Homes of 3-4 beds are places where 3-4 adults who are not related to the operator reside and receive care, treatment or services above the level of room and board and that may include up to seven hours of nursing care per resident. Services typically include supportive home care, personal care and supervision. Services may also include behavior and social supports, daily living skills training and transportation performed by the operator or designee of the operator. Includes homes which are the primary domicile of the operator or homes where staff are hired by a third party who also controls the place. Also includes homes specified under s. 50.01 (1) (a) 1 of the Wisconsin Statutes and certified under DHS 82 of the Wisconsin Administrative Code.

c. Community-based Residential Facility for elders or persons with physical disabilities is a place where 5 or more adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision and training. Services include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation and up to seven hours per week of nursing care per resident.

   Community-based residential facility (CBRF) for persons with developmental disabilities is a place where up to 8 adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision and training. Services include supportive home care, personal care, supervision, behavior and social supports, daily living skills training, transportation and up to seven hours per week of nursing care per resident.

d. Residential Care Apartment Complex (RCAC) are services provided in a homelike, community-based setting where 5 or more adults reside in their apartment that are separate and distinct from each other. Persons who reside in the facility also receive the following services: supportive services (e.g., laundry, house cleaning), personal assistance (e.g. personal care), nursing services (e.g., wound care, medication management), and assistance in the event of an emergency (e.g., PERS and response).

Attachment B – Talking Points about Residential Services in Managed Long-Term Care

Goal: The purpose of this document is to formulate a series of talking points that will serve as a foundation for changing the way residential services are discussed with Family Care members. Ultimately, the goal is to renew and reclaim our commitment to one of the most fundamental and essential Family Care principles:

> *To ensure that people with long-term care needs are safe and cared for in their own homes and community settings as long as possible, with services provided in residential settings only when it is the least restrictive and most integrated location to meet the person's needs. (Note: this italicized language is from the CMS Administration on Community Living.)*

These talking points may be used by DHS, MCOs and others to reground Family Care staff at all levels on core program values of keeping people in their own homes as long as possible and using residential facilities only when it is not possible to keep someone safe and secure in their own home.

These talking points will also provide input to program-wide guidelines for care managers to use when working with members to develop plans for independent living in their own homes and potential use of residential services. These points could be used to update program documents such as member handbooks and the Full Partner booklet, to revise enrollment and options counseling delivered by ADRCs, for communications with members and their families, and for general communications about Family Care.

Residential Services Talking Points

These talking points are provided to be useful to MCOs in implementing these guidelines and explaining program policy to members and their representatives.

- Many people need help with daily activities such as bathing, transportation, housekeeping and many people get that help through their own support network of family members, friends, neighbors or they pay others for some of the tasks with which they need help.

- Some people may not be able to get all of the help they need from their own support network or they may be afraid that even with the help they are getting from their support network that they are not safe and secure in their home.

- Studies and surveys demonstrate that most people want to live in their own home or apartment, among family and friends. When people live in their own homes or in their family's homes, they have more power over their lives. They can decide when to do certain things, such as when to get up and eat meals, and how their day flows.

- All people – including people with disabilities and seniors - should be able to live at home with the supports they need, participating in communities that value their contributions.

- Adults with physical or intellectual disabilities and frail elders may qualify to get the help they need to remain in their own home through a program called Family Care. Family Care is a state-run program funded by state and federal tax dollars. The State of Wisconsin Department of Health Services (DHS) contracts with managed care organizations (MCOs) to create networks of providers qualified to provide the long-term care services needed by members.

- In Family Care, a MCO care management team works with each individual to develop care plans that are tailored to each individual's unique life circumstances, health and safety needs, and the needed health and long-term care supports that can improve their quality of life. Family Care focuses on the services that friends and family are not able to provide to keep the person safe and secure in their own home setting.

- Usually, living at home is the most cost-effective and desired outcome or option to consider.

- The member and their care team incorporate ways for families, friends and people in the community to become part of the care plan. Family Care services do not replace care and assistance that family and friends provide.

- Family Care is committed to promoting community living and finding new ways to make sure that the supports people with disabilities and seniors need to live in the community are available to them so they may live with respect and dignity as full members of their communities.

- At the same time, DHS and MCOs must be careful about how public resources are spent so that each Family Care member can get the services as they need them. Members, families and friends share responsibility for the most cost-effective use of these limited public funds. Cost-effective is defined as effectively supporting an identified long-term care outcome at a reasonable cost and effort.

- Members' long-term care needs may change over time as their health status and personal life circumstances change. Individuals may feel that they are able to stay safely in their own home now with a little help, but may be concerned that they may need more services at some point in the future, or they might need more help now to be safe and secure in their own home.

- Family Care benefits are designed to be flexible and to change over time to adjust for the services members need. Providing the right service, in the right amount in the right place and at the right time is important. Family Care builds on supports the members have in their own life and help to identify other supports or relationships the member can develop. Building on, rather than replacing, the assistance a member gets from family, friends, faith connections and the community, Family Care helps to maintain those important relationships and allows for Family Care dollars to be used where and when they are needed.

- When a member's long-term care needs cannot be supported by friends, family or other community connections, the MCO care team will work with the member to identify the services and assistance are needed. As much as reasonably possible, the Family Care MCOs will try to accommodate a member's preferences but members, families and guardians must remember that they have a responsibility to choose among the cost-effective options that are available to them to meet the person's long-term care needs. For example, if two different providers offer the assistance a member needs, MCOs will purchase the more economical service.

- Family Care may offer supports ranging from help with household chores to paying for services provided to someone living in a residential facility, except room and board. Moving members into residential facilities should happen only when the right level of services and supports for the member to remain in his or her home have not been possible.

- Sometimes, people use their own funds to move into a residential facility months or years before they apply and qualify for Family Care. In some cases, people spend a significant amount of their own money at these facilities. This does not necessarily mean that Family Care will be able to pay for that facility when a person becomes eligible for Family Care.

    - The MCO care team will work with the individual to evaluate his or her long-term care needs with a focus on arranging for supports and services the individual would need to return to his/her home. Family Care will only pay for residential care if the person's long-term care needs cannot be met at their own home.

  - Even if the MCO determines that residential care is the only option for a member, the person may not be able to stay at the same facility. That facility may not have a contract with the MCO or may not be willing to accept the rate Family Care pays for that facility. Family Care, like other publicly funded programs, typically pays less than the private pay rates a person might have paid. Family Care cannot force the provider to accept the Family Care rates and the provider cannot force Family Care to pay more than the Family Care rates.

  - Most importantly, Family Care wants to provide supports to increase independence, stabilize health, or assist individuals who are moving out of intensive community supports or institutional settings to establish or re-establish their independence and life in their home and community.

- For young adults who are preparing to move out on their own, Family Care will help them gain skills to make this transition successfully and hopefully help them develop job skills to pay for an independent living setting.

- Family Care teams talk with members about many kinds of supports and services that will help them live at home safely. This might include building a wheelchair ramp or using technologies like medical alert systems or medication dispensing devices. This equipment makes sure Family Care can meet most members' health and safety needs in their homes and apartments. These new services for communications and other technologies make it possible for elders and people with disabilities to live independently, in their own homes and communities.

- Sometimes people's needs for care changes—the needs may increase as their physical health declines and may decrease as their physical health improves. Family Care services will also change accordingly; the amount and intensity of services will fade as the person's need for those services becomes less.