Executive Office of Elder Affairs

RESPECT INDEPENDENCE INCLUSION

Home Care Program
MCLE Training

May 2th, 2023

Introduction

- Lynn Vidler - Director of Home & Community Programs
  - Email: Lynn.Vidler@mass.gov
- Devon Garon - Assistant Director of Home & Community Programs
  - Email: Devon.Garon@mass.gov
- Desiree Kelley – Clinical Nurse Manager
  - Email: Desiree.Kelley@mass.gov
- Shannon Turner – Home Care Program Coordinator
  - Email: Shannon.K.Turner@mass.gov
- Melissa Enos – Home Care & Program Analytics Nurse
  - Email: Melissa.A.Enos@mass.gov

Introduction

- Brian Glennon – Home Care Waiver Program Manager
  - Email: Brian.M.Glennon@mass.gov
- Nicholas Roberts – Home Care Data Analyst
  - Email: Nicholas.P.Roberts@mass.gov
- Dawn Hobill – Quality Manager
  - Email: Dawn.Hobill@mass.gov
- Joel Bartlett – Home Care Provider Coordinator
  - Email: Joel.D.Bartlett@mass.gov
- Dana Beguerie – Frail Elder Waiver / Senior Care Options Liaison
  - Email: Dana.Beguerie@mass.gov

EOEA Mission

The Executive Office of Elder Affairs (EOEA) works to ensure all older people and their caregivers have opportunities to thrive in the communities of their choice.

EOEA Home Care Program

The Home Care Program provides care management and in-home support services to help older adults, people with disabilities, and people with Alzheimer's Disease or related dementia successfully age in place within Massachusetts. Services are available based on assessed needs.

Agenda

- What is an Aging Services Access Point (ASAP)?
- Home Care Eligibility & Services
- Frail Elder Waiver and ANCHOR Overview
- Home Care Referral Examples
- Questions

Aging Services Access Points (ASAPs)

25 ASAPs each serve a unique geographic area of the Commonwealth**

Home Care Program Functions

Information & Referral
Nutrition (home-delivered meals)
Care Management
- Home Care Program Eligibility & Assessment
- Home Care Program Enrollment
- Advocacy & Education

Care & Support Coordination
- Authorization & purchase of Home Care services
- Coordination of comprehensive community care
- Management of procured provider network
  - Provider vetting and monitoring
  - Negotiation of rates and services

*For discussion purposes only. Not for distribution
** Baypath & Springwell merger occurring now

ASAP Functions

- ❑Assist people regardless of income or eligibility/enrollment in the home care program
- ❑Provide resources/community service information at no-cost

Home Care Eligibility & Services

Age & Residence Eligibility

Function & Need Eligibility

- **Functional Impairment Level (FIL):**
  - Require assistance with at least One Activity of Daily Living (ADL)

OR

  - 6 or more Instrumental Activity of Daily Living (IADL) impairments

AND

  - *Intervention that Home Care will provide to meet this need at the time of* ***enrollment*** - a critical unmet need (any ADL, meal preparation, food shopping, home health services, medication management, Respite, transportation for medical treatments)*

Exceptions to the Home Care Eligibility (only need 4 IADLs):	
At Risk:	**Older Adults who are at risk due to a variety of factors, including, but not limited to substance abuse, mental health problems or cultural and linguistic barriers.**
Protective Services:	**Older Adults who are receiving or are eligible to receive Protective Services.**
Congregate Housing:	**Older Adults residing in a Congregate Housing Facility.**
Waiver Consumers:	**Older Adults who are eligible for the Home and Community Based Waiver Program.**

*This is for initial eligibility only

Income & Cost Share

- **Any Income**
- **A co-pay can only be assessed after a financial assessment has been completed**
- **Cost share contribution based on Income & MassHealth:**
  - Annually adjusted based on cost of living adjustment (COLA)
  - Exceptions to income: some VA benefits, pooled trust, etc.

2023 Cost Share Schedule		
Voluntary Donation	**Fixed Monthly Max Copay** (ranges from $10-$199, not to exceed actual cost of qualifying services)	**% Based Monthly Copay** (based on qualifying services received)
Individuals whose annual income is below $14,982	Based on a sliding scale, Individuals whose annual income is $14,983-$33,659	Based on a sliding scale, Individuals whose annual income is $33,600 and above
A couple whose annual income is below $20,176	Based on sliding scale, A couple whose annual income is $20,177-$47,626	Based on a sliding scale, A couple whose annual income is $47,627 and above
MassHealth members whose income is at or below 300% SSI FBR ($2,742/month in 2023) will not have a copayment for Home Care Services, including Medicare Savings Plan		

Home Care Services

- Adult Day Health
- Alzheimer's/Dementia Coaching
- Behavioral Health Services
- Chore
- Companion
- Complex Care Training & Oversight (Skilled Nursing)
- Electronic Comfort Pets (non-waiver only)
- Environmental Accessibility Adaptations
- Evidence Based Education Programs
- Goal Engagement Program
- Grocery Shopping/Delivery Services
- Home Based Wandering Response Systems
- Home Delivered Meals
- Home Delivery of Pre-packaged Medication
- Homemaker
- Home Health Aide
- Home Safety/Independence Evaluations (Occupational Therapy)
- Laundry Services
- Medication Dispensing System
- Nutrition Assessment/Counseling
- Orientation & Mobility
- Peer Support
- Personal Care
- PERS/Enhanced PERS
- Respite
- Supportive Day Program
- Supportive Home Care Aide
- Transportation
- Transitional Assistance
- Vision Rehabilitation

Home Care Programs

Care Plans are developed and implemented based on a consumer's unique and specific needs

Home Care Basic-Non-Waiver, Home Care Over Income, Respite Over Income	Enhanced Community Options (ECOP)	HCBS Frail Elder Waiver (FEW) MassHealth Only
Basic level of care needs **Example Care Plan #1:** • Home Delivered Meals 5 meals/week • Homemaking/Personal Care 2-3 hours/week **Example Care Plan #2:** • Home Delivered Meals 3 meals/week • PERS Monthly • Homemaking 1.5 hours/week	**Nursing Facility Level Of Care Needs** **Example Care Plan #1:** • Home Delivered Meals 5 meals/week • PERS Monthly • Homemaking/Personal Care 2-3 hours/week **Example Care Plan #2:** • Adult Day Health 1 day/week • Homemaking 1.5 hours/week • PERS Monthly	**Nursing Facility Level Of Care Needs: 2 Types of Programs based on Formal Support Needs** **Home Care Basic-Waiver** **Example Care Plan:** • Home Delivered Meals 5 meals/week • Homemaking/Personal Care 3 hours/week • Informal Supports • Lower Formal Support Need **CHOICES** • Informal Support • Higher Formal Support Need • Services to meet needs • Up to 24/7 care

Sample Care Plans Based on Program above

Individual Care Plans are based on actual consumer's assessed needs

What information do you need to make a Home Care Referral?

*For discussion purposes only. Not for distribution.

Care Planning & Care Management

Initial Assessment

- Initial on-site assessment (OSA) to determine consumer eligibility
- Functional Needs Assessment and identification of supports in place
- Initial Service Plan developed with consumer to address identified unmet needs

Ongoing Assessment

- Visit schedule of an OSA at least every six months
- Reassessment of Functional Needs
- Ongoing review of care plan/service plan and consumer satisfaction

Annual Assessment

- Annual re-determination of home care program eligibility
- Review of care plan/service plan and consumer satisfaction
- Annual re-determination of personal care needs, as well as clinical eligibility for waiver and ECOP by ASAP RN

Frail Elder Waiver (FEW)

HCBS/Frail Elder Waiver Eligibility

Requires nursing facility level of care (LOC)

- Clinical Eligibility Criteria based on Federal Regulations

Participants must be financially eligible

Frail Elder Waiver (FEW) Eligibility

Clinical Eligibility

Advocacy & Navigating Care in the Home with Ongoing Risks (ANCHOR)

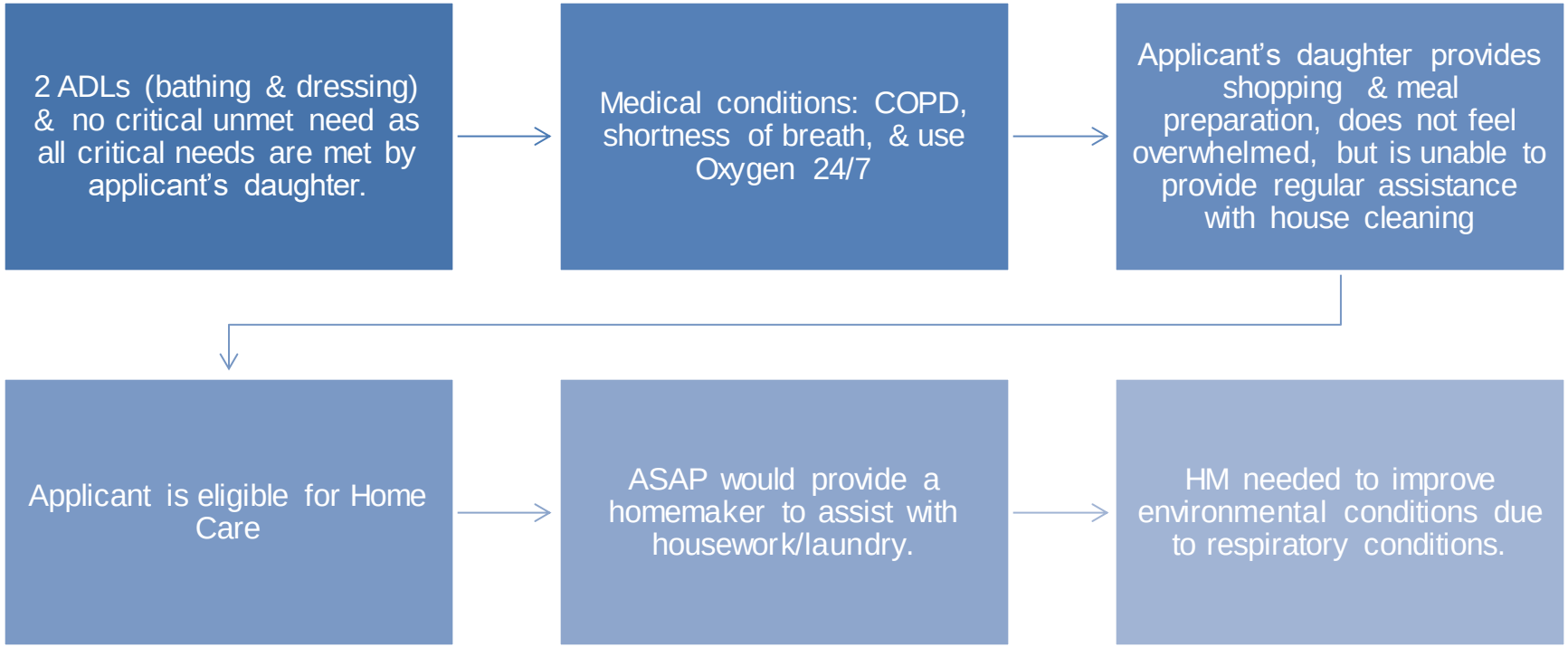
ANCHOR (Advocacy & Navigating Care in the Home with Ongoing Risks)

A program that provides highly focused goal-oriented care management that provides a more frequent, rigorous and time intensive delivery of advocacy and other support to older adults with behavioral health needs who are at risk of institutionalization or homelessness due to their inability to accept or retain services

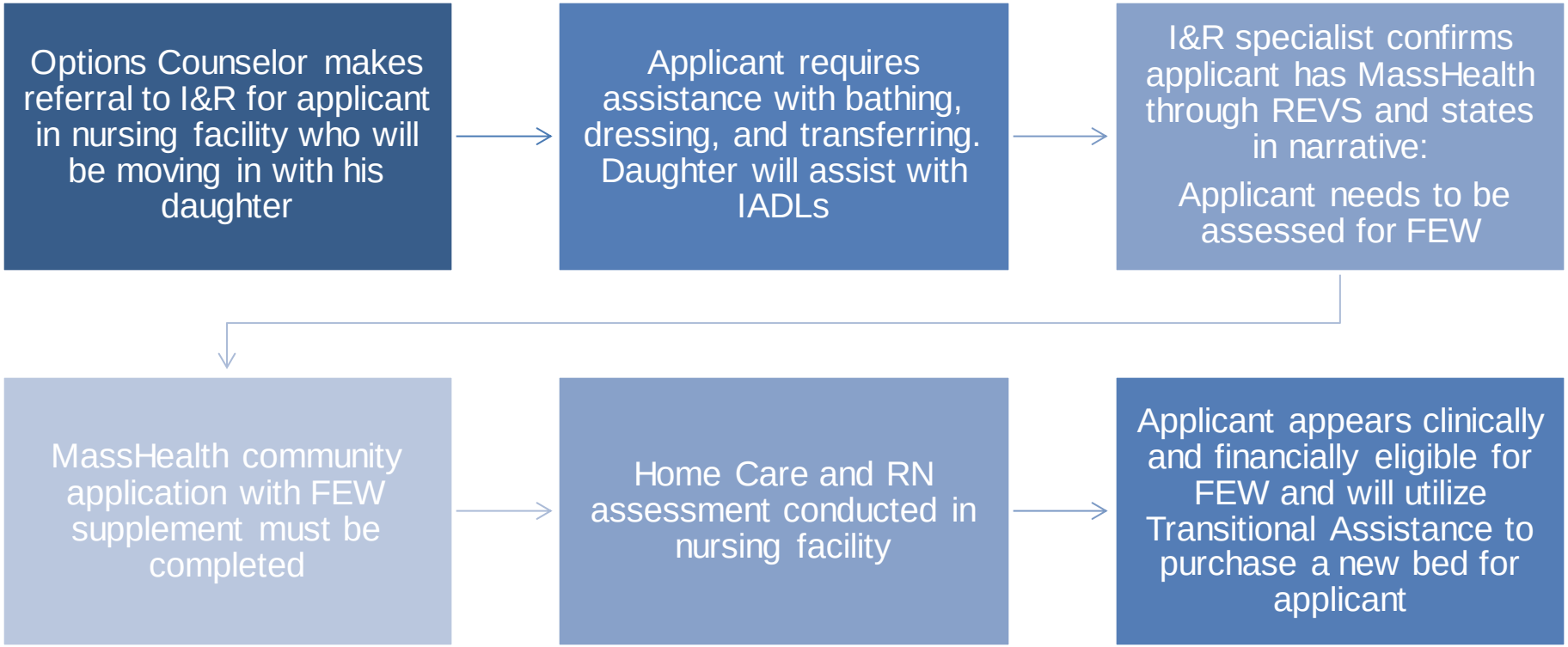
- **Anxiety, suspicion, paranoia**
- **Substance use disorder**
- **Family dynamics that impact service delivery**
- **A constant level of risk in their lives that may impact service utilization**
- **Chronic homelessness or history of housing instability**
- **Chronic behavioral health concerns**

Home Care Referral Examples

Applicant Journey Map: Home Care Basic



Applicant Journey Map: Frail Elder Waiver



Connect with EOEA

- **Mass.gov**:
- Aging Services Access Points (ASAPs) in Massachusetts | Mass.gov

- **MassOptions:**
- 1-800 243-4636
- https://www.massoptions.org/massoptions/

•Shannon Turner – Home Care Program Coordinator
•Email: Shannon.K.Turner@mass.gov

Questions