**A**dvocacy & **N**avigating **C**are in the **H**ome

with **O**ngoing **R**isks

February 1, 2019

**Purpose:**

Elders with recurrent, fluctuating behavioral health needs often require more frequent, intense care management, support and advocacy than the standard home care case management system can sufficiently provide. Advocacy & Navigating Care in the Home with Ongoing Risks (ANCHOR) is a highly focused care management and coordination level that provides a more frequent, rigorous and time intensive delivery of advocacy and other support to elders with behavioral health needs who are at risk of institutionalization or homelessness due to their inability to accept or retain services.

**Identifying Consumers for Advocacy & Navigating Care in the Home with Ongoing Risks (ANCHOR):**

Elders or consumers in need of this level of care management are generally those with suspected or confirmed behavioral health diagnoses that impede or reduce their ability to accept services. However, behavioral health is not a requirement of the program.

These behavioral health diagnoses may include, but are not limited to:

* anxiety;
* substance use;
* chronic behavioral health concerns

Related individual or consumer behaviors may include, but are not limited to:

* chronic homelessness;
* suspicion, paranoia
* history of housing instability
* history/pattern of refusing multiple workers and/or vendors;
* family dynamics that cause service delivery issues;
* a constant level of risk in their lives for one reason or another

These individuals or consumers may often be “pre- Protective” and the additional support may prevent the need for active Protective Service (PS) intervention due to the remediation or reduction of behaviors. However, ANCHOR is not a substitute for PS. EOEA expects all abuse, neglect and exploitation situations to be appropriately reported. ANCHOR is not a substitute for ongoing services for PS:

1. The expectations of PS's collaboration with ANCHOR after substantiation of a case is to bridge the gap in care/services and to ensure continued support with the ANCHOR CM. PS is expected to keep those cases referred to ANCHOR in ongoing services for 1 to a maximum of 2 months. PS and ANCHOR CM are expected to work together on goals and services for the consumer, which may include joint monthly home visits and bi-weekly calls to the consumer while in ongoing services with PS and ANCHOR.

2. EOEA approval is needed for those PS investigations that are substantiated and not moved into ongoing services.

4. Documentation should support the purpose of PS’s ongoing involvement with the ANCHOR program for any cases that go beyond the two month ongoing services period, with EOEA consultation.

5. An interdisciplinary team meeting should take place with ANCHOR prior to PS’s termination of ongoing services.

The following are examples of individuals who may be appropriate for ANCHOR:

1. A consumer who is resistant to accepting services based on the above characteristics (list not exclusive).
2. A consumer who states they will accept service, but then has a history of turning workers away, changing worker to worker, changing provider agency to provider agency thus not accepting services.
3. A consumer who may need extra time, extra efforts and reassurance in order to accept necessary services to maintain safety and health and welfare.

The following is an example of individuals who are **NOT** appropriate for ANCHOR and therefore not eligible for ANCHOR higher reimbursement rate:

1. A consumer who is accepting of service but is continually filing complaints about the worker.
2. A consumer who is accepting of service but either consumer or family member are continuously calling and registering complaints and/or requests or a professional in the community is requesting additional ASAP involvement.

**Enrolling and Serving ANCHOR Consumers:**

The ANCHOR Care Manager’s responsibility is to work within an Interdisciplinary team, consulting with Home Care, Protective Services, Nursing and other clinical specialists at an accelerated or escalated frequency as necessary.

**Reimbursement:**

For consumers enrolled in ANCHOR and not enrolled in a home care program, the ASAP will receive $241.22 / month in case management.

For consumers enrolled in ANCHOR and one of the four programs listed below, the ASAP will receive an additional $103.48 / month in case management. The $103.48 is the difference of the Chapter 257 ECOP Case Management rate of $241.22 and Basic Case Management rate of $137.74.

* Home Care Basic / Waiver
* Home Care Basic / Non-Waiver
* Home Care / Over-Income
* Respite / Over-Income

There is no ANCHOR differential for consumers enrolled in ECOP / Non-Waiver or Choices / Waiver.

A higher reimbursement rate ($241.22/month) for this increased level of care management would allow for a reduced caseload, thus providing additional time to help the consumer meet goals, and to adjust to services on their own, individualized time frame. This higher level of care management would allow for the provision of contact with the consumer at a minimum of every other week either by telephone or home visit with a minimum monthly home visit, a high number of phone calls and multiple consultations, all requiring timely, clear, concise and thorough documentation. Such documentation must reflect every individualized effort that has been made in supporting the consumer. Documentation must support the need for the elder’s enrollment in ANCHOR, active case management and interventions being provided.

Elder Affairs will collect data to better understand who is served by ANCHOR and the level of effort necessary to serve these consumers. Data collected will be from the SAMS Consumer record including, but not limited to Consumer Details, Journal Notes, Activities & Referrals, Care Enrollments, and Services Deliveries. It is essential that ASAP’s close a consumer’s ANCHOR enrollment once the consumer is stabilized within a program and the consumer is receiving ongoing services. While each consumer’s situation is different, general expectation for ANCHOR enrollment is 6 -9 months. Additional enrollment past this duration requires Executive Office of Elder Affairs (EOEA) consultation. EOEA understands some consumers may need more than 9 months of ANCHOR to encourage program and service acceptance, monitor and support the relationship between the consumer and worker, mediate conflict, facilitate resolutions, etc. For these consumers who will need ANCHOR beyond 9 months, a request must be made to the Home Care Team at EOEA. Documentation must support the need to extend past the expected duration of ANCHOR.

**Expectation for ANCHOR:**

Regular frequent activity between the Care Manager and consumer including additional home visits, an increased number of phone calls and multiple consultations. Minimum contact is defined as once every other week either telephone or home visit; with a minimum monthly home visit, with documentation to support contact type, reason, goal and outcome. Purpose of the ANCHOR pilot is to connect, advocate, build rapport and relationships while assisting the elder in navigating care and community resources in an effort to stabilize and receive services through a home care program. Documentation should support need, rapport building and advocacy. Documentation should support purpose of the program and need for elder to be enrolled in ANCHOR and for ASAP reimbursement.

**Consumer Record Data Entry:**

A new Care Enrollment “ANCHOR” is entered into SAMS for all consumers identified for the ANCHOR program regardless of enrollment in other Home Care programs. Two types of service delivery exist for ANCHOR:

* + - 1. ANCHOR Only
      2. ANCHOR Supplement

Service deliveries do not need to be entered on the last day of the month since reimbursement will be through E-invoicing and not through the Payment Voucher. A service delivery of “ANCHOR Only” is entered for each month a consumer is enrolled in ANCHOR **AND** no other Home Care Program. A service delivery of “ANCHOR Supplement” is entered for each month a consumer is concurrently enrolled in ANCHOR **AND** another Home Care Program. The new “ANCHOR Supplement” service delivery is available for the following programs:

* Home Care Basic/Non-Waiver (HCB/NW)
* Home Care Basic/Waiver (HCB/W)
* Home Care Over-Income (HCOI)
* Respite Over Income (ROI)

Enrollment in ANCHOR concurrent with a Home Care program enrollment as listed above would be utilized when a consumer is accepting services and continues to need additional support through ANCHOR. (i.e. for the purpose of ensuring a smooth transition to services and from one care manager to another. )

Creation of four new Journal Entry types which include:

* ANCHOR Initial Contact *(utilize when first opening a consumer in ANCHOR)*
* ANCHOR Goals *(Utilize when first opening a consumer in ANCHOR for what goal or focus the CM and consumer will be working on together)*
* ANCHOR Termination *(Utilize when terminating a consumer from ANCHOR)*
* ANCHOR Extend Duration *(Utilize when requesting extended duration from EOEA, for the consumer to stay open in ANCHOR longer than 9 months)*

Two new Activities and Referrals (A&R) are required for ASAPs to utilize during ANCHOR enrollment. Use of Status Date, Due Date, and Date of Completion is required according to ASAP Business Practice:

* ANCHOR Initial Contact
* ANCHOR Home Visit

HCB/NW, HCB/W, HCOI, ROI A&R action items for Home Visit, Reassessment, and Annual Re-determination shall be used for ANCHOR Supplement enrolled consumers when the ANCHOR monthly home visit is completed along with scheduled Home Care Program Home Visit. ASAPs are not required to data enter two A&R home visits in the same month (ANCHOR A&R Home Visit and Program visit A&R). ASAPs are expected to data enter an ANCHOR A&R Home Visit for the months in which a Program visit A&R is not planned. Example: If the consumer is due to have a 6 month reassessment in March, ASAPs will use the Home Care Program Reassessment action type as their ANCHOR Home Visit A&R without an additional data entered unique ANCHOR Home Visit A&R. The CM will address ANCHOR related goals and interventions during the regularly scheduled visit.

**Ending ANCHOR:**

Once services are accepted, CM staff can closely monitor the relationship between the consumer and worker, mediate conflict, facilitate resolutions and provide on-going support to workers.

When the consumer reaches a point where they are accepting of services or the reason for the referral has been resolved, the consumer can be deemed ready for transfer and will be terminated from ANCHOR. The ANCHOR Care Enrollment must accurately reflect (using termination reasons) any reason ANCHOR is terminated or ended.

If the consumer is followed by an ANCHOR Care Manager and the ongoing Home Care or ECOP Care Manager will be a different person, ideally a warm handoff is preferred. Documented interdisciplinary conversations based on the consumer’s particular needs when the consumer is transferred from one Care Manager to another Care Manager is required. A warm handoff is a handoff that is conducted in person, between two members of the interdisciplinary team, with the consumer (and family if present). At a minimum, when a warm handoff is not an option, a face-to-face interdisciplinary case conference between the ANCHOR Care Manger and the Home Care or ECOP Care Manager will occur discussing the consumer’s particular needs. Clear communication with the consumer regarding the transition is required.

**Invoicing for ANCHOR Consumers:**

Invoicing for ANCHOR consumers will occur through E-invoicing. On the 12th of each month, the ANCHOR invoice will be available in the SIMS invoices list within E-invoicing. The invoice will have one row for ANCHOR Only service deliveries and one row for ANCHOR Supplement service deliveries. The units for each row will be based on service deliveries for the prior month. The amount of the invoice will be determined by the number of units for each service delivery type and the ANCHOR only ($241. 22) and ANCHOR Supplemental ($103.48) rates.