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PROGRAM INSTRUCTION (PI)

EOEA PI-19-02
REF: EOEA PI-09-13
EOEA PI-14-01

TO: Aging Services Access Points (ASAPs)
Executive Directors
Program Managers
Nurse Managers
Contracts Managers

FROM: Robin Lipson, Acting Secretary *RL*

DATE: March 20, 2019

RE: **New Home Care Services and Service Description Updates**

Purpose:

This Program Instruction (PI) identifies new services and updates purchased service descriptions for the Home Care Program including the 1915(c) Home and Community Based Services Waiver as of January 1, 2019. This PI supersedes any related, previously issued service descriptions.

Background and Program Implications:

The Executive Office of Elder Affairs (EOEA) is responsible for establishing and defining the in-home support services offered through its Home Care Program. The service descriptions contained in this PI have been revised in accordance with the renewed Frail Elder Waiver (Waiver) with additional input from Aging Services Access Points (ASAPs).

The following are new purchased services, included on the Waiver list of services:

- Evidence Based Education Programs
- Goal Engagement Program
- Orientation & Mobility
- Peer Support (Certified Older Adult Peer Specialist)

The following existing purchased service has been added to the Waiver list of services:

- Enhanced Technology/Cellular Personal Emergency Response System (PERS)

The following updates to existing services and service descriptions for purchased services are not new to the Waiver list of services.

- Complex Care Training and Oversight (formerly Skilled Nursing)
- Home Safety/Independence Evaluations (formerly Occupational Therapy)
- Transitional Assistance (added housing search support)

Required Actions:

ASAPs must use the attached service descriptions as “Attachment A” for EOE standard Provider Agreements.

Effective Date: January 1, 2019

Contact: If you have any questions regarding this Program Instruction, please contact Brenda Correia, Coordinator for Elder Community Support Programs, at:

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Attachments: Attachment A Service Descriptions

Attachment A

Complex Care Training and Oversight

Complex Care Training and Oversight (formerly Skilled Nursing) is a periodic, episodic service that includes Medication Management (e.g., filling medication cassettes, etc.) as well as development and ongoing management and evaluation of the consumer's Home Health Aide Plan of Care, for purposes of monitoring the consumer's underlying conditions or complications to ensure the unskilled care is successfully addressing the consumer's needs. Medication management is appropriate when the need is unable to be met by MassHealth State Plan Services.

Complex Care Training and Oversight services must be performed by a Registered Nurse, or a Licensed Practical Nurse under the supervision of a Registered Nurse. All nurses must have a valid Massachusetts license. Agencies that provide Complex Care Training and Oversight services under the Waiver do not need to meet the requirements for participation in Medicare, as provided in 42 CFR §489.28.

Attachment A

Enhanced Technology/Cellular Personal Emergency Response System (PERS)

Enhanced Technology/Cellular Personal Emergency System (PERS) provides personal emergency response service for Consumers who are assessed as having a need for this service. PERS is available according to need regardless of whether the consumer has a landline or a cell phone. Cellular PERS functionality includes:

- Cellular capacity is built into the PERS unit, allowing emergency calls to go to the monitoring center.
- A help button, which when activated by the consumer triggers immediate response 24/7 via two-way voice connection through the PERS device.

Cellular PERS may also include fall detection technology. This option provides 24/7 access to emergency assistance both inside and outside the home, GPS-monitoring, and can automatically detect falls. The functionality includes:

- While in the home the button works in conjunction with the in-home communicator.
- If help is needed away from the home, the button is equipped with a cellular two-way speakerphone and locating technologies designed to support the Response Center in locating the user and sending help. While outside the home, the button becomes the communicator.

Agencies that provide Enhanced Technology/Cellular PERS under the Waiver are not required to meet the requirements for participation in Medicaid, as provided in 130 CMR 409.00 (MassHealth Durable Medical Equipment regulations). This service is not duplicative of services available through the MassHealth State Plan. Consumers may not receive Enhanced Technology/Cellular Personal Emergency Response System (PERS) at the same time that they receive State Plan PERS.

Attachment A

Evidence-Based Education Programs (EBPs)

Evidence-Based Education Programs (EBPs) educate consumers and provide them with tools to help them better manage chronic conditions (including, but not limited to, diabetes, heart disease, arthritis, HIV/AIDS, depression), and to better manage/prevent falls. EBPs promote the active engagement of consumers to undertake self-management of chronic conditions by teaching behavior management and personal goal-setting.

EBPs also provide education to caregivers to help increase caregiver knowledge, skills, self-efficacy and well-being. EBPs can also help family and friends caring for older adults with long term health conditions to develop skills to cope with the everyday demands of caregiving and improve confidence for better self-care.

EBPs are either peer-facilitated self-management workshops that typically meet weekly for six or eight weeks or one-to-one personalized interventions with a trained coach.

EBP topics include diet, exercise, medication management, cognitive and physical symptom management, problem solving, relaxation, communication with healthcare providers, and dealing with difficult emotions. Each course requires trained facilitators who adhere to prescribed, evidence-based and validated modules for each workshop. Workshops are broken down to include training in: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) the appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) the appropriate use of medications; 4) communicating effectively with family, friends, and health professionals; 5) optimal nutrition; 6) decision making; and, 7) how to evaluate new treatments. Workshops and/or one-to-one personalized trainings are highly interactive, where mutual support and success build consumer confidence in their ability to manage their health and maintain active and fulfilling lives.

Transportation may be authorized and provided as a separate purchased service to assist with a consumer's access to EBPs.

In SAMS, the service unit type is per session which is defined as an individual workshop. Participants may enroll in no more than two EBPs per calendar year. A completer of an education program is defined as a participant who attends 4 of the 6 sessions or 5 of the 8 sessions.

EBPs may include, but are not limited to:

- Arthritis Self-Management Program (English and Spanish)
- Better Choices, Better Health
- Cancer: Thriving and Surviving Program
- Chronic Disease Self-Management Program (CDSMP)
- Chronic Pain Self-Management Program
- Cuidando Con Respeto (Spanish Savvy Caregiver Program)
- Diabetes Self-Management Program
- Enhance Wellness
- Fit for Your Life
- Healthy Eating for Successful Living
- Healthy Ideas (identifying depression empowering activities for seniors)
- Living La Vida Dulce (Spanish Diabetes Self-Management Program)
- Matter of Balance (falls prevention)

- Positive Self-Management Program (HIV/AIDS)
- Powerful Tools for Caregivers
- Savvy Caregiver
- Tai Chi for Healthy Aging
- Tomando Control de su Salud (Spanish CDSMP)

A provider agencies' EBP facilitator must be trained and certified by the Healthy Living Center of Excellence or by the Self-Management Resource Center. Facilitators must possess a Certificate of good standing from the Healthy Living Center of Excellence or the Self-Management Resource Center.

Attachment A

Goal Engagement Program

The Goal Engagement Program consists of a set of highly individualized, person-centered services that use the strengths of the Consumer to improve her/his safety and independence. Goal Engagement Program services engage Consumers to identify and address their goals related to increasing functional independence, improving safety, decreasing depression and improving motivation, including addressing barriers to achieve and maintain maximal functional independence in their daily lives.

Consumers receive a structured set of home visits conducted by a multidisciplinary team consisting of an Occupational Therapist (OT), a Registered Nurse (RN), and a home repair specialist. The Consumer and OT work together to identify areas of concern using a standardized assessment tool. Areas evaluated include ADLs, IADLs, maintaining health and community engagement. Based on the assessment, the OT may recommend strategies that can be implemented by the home repair specialist to increase home safety and mitigate conditions that pose a risk or barrier to safe, independent daily functioning, such as changes necessary for fall prevention. Using a motivational interviewing approach, the OT engages the Consumer to develop goals based on difficulties found in the self-report, observations during the assessment, and what the Consumer identifies is meaningful activity for them in order to preserve their independence and prevent institutionalization. The Consumer and OT develop an action plan for addressing these goals. At each visit, the multidisciplinary team and Consumer reviews the Consumer's goals, refines them as desired, and practices the action plan with the OT or RN. Each visit includes training the Consumer to harness their motivation to work toward their goals.

The RN addresses clinical concerns that inhibit daily function, such as pain, mood, medication adherence and side effects, mobility, and communication with healthcare providers. RN visits focus on goals set by the Consumer rather than on adherence to medical regimens unless this is the Consumer's goal.

Each member of the multidisciplinary team focuses on the Consumer's identified goals to customize the service according to the action plan. This service includes coordination and in-home visits between the OT, RN and home repair specialist (as identified by goals) to ensure services are targeted to meet the goals identified by the Consumer.

Goal Engagement Program services include up to ten in-home visits by the OT or RN. The total number of visits is not to exceed ten but must include at least one visit by RN. Purchases related to home safety, minor home repairs, related items and services are limited to \$1,800 per Consumer, per year, when reimbursed on a fee-for-service basis. Consumers are limited to one set of Goal Engagement services per calendar year.

Occupational therapy elements of the service must be performed by an OT with a valid Massachusetts license, or by either a certified Occupational Therapy assistant or an Occupational Therapy student under the direct supervision of a licensed Occupational Therapist.

Skilled nursing elements of the service must be performed by an RN with a valid Massachusetts license.

If the scope of work involves minor home repairs, agencies and individuals employed by the agencies must possess any licenses/certifications required by the state (e.g., Home Improvement Contractor, Construction Supervisor License, Plumber's license, etc).

Staff providing OT and nursing must be CAPABLE certified through Johns Hopkins University.

Attachment A

Home Safety/Independence Evaluations

Home Safety/Independence Evaluations (formerly known as “Occupational Therapy”) are periodic, episodic services provided by an Occupational Therapist (OT) to provide in-home evaluations to identify and mitigate home safety risks. The service includes observation and assessment of the Consumer’s normal functioning and completion of day-to-day tasks, including but not limited to ADLs and IADLs, in their living environment.

The service also includes recommendations to modify or adapt the Consumer’s approach to such activities and tasks to prevent injury or disability.

Home Safety/Independence Evaluations are justified when an identified need is unable to be met by State Plan services or as a maintenance program beyond the scope of coverage in the MassHealth State Plan. Services are designed to improve the quality of life by recovering competence, preventing injury or disability, and improving the individual’s ability to perform tasks required for independent functioning so that the individual can engage in activities of daily living.

Services must be considered by the therapist to be necessary for the Consumer to improve, develop, correct, rehabilitate, or prevent the worsening of physical, cognitive or sensory functions that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies or injuries; or required to maintain or prevent the worsening of function. Services may also include the training and oversight necessary for the Consumer, family member or other person, to carry out the maintenance program.

The service could also include recommendations to enhance home safety, including recommendations for home repair, home modification, or assistive devices needed to enable the Consumer to engage in recommended self-care strategies. Home Safety/Independence Evaluations services must be authorized by the Care Manager in the Service Plan. This service is not subject to the Medical Referral Requirements found at 130 CMR 432.415 (MassHealth Therapist Regulations that describe the medical referral requirements necessary as a prerequisite to MassHealth payment) or the requirements for Prior Authorization found at 130 CMR 432.417 (MassHealth Therapist Regulations that describe the prior authorization process for therapy services). This service cannot be provided in settings other than the Consumer’s place of residence. The Home Safety/Independence Evaluations service may not be provided at the same time that a Consumer is enrolled in the Goal Engagement Program waiver service.

Home Safety/Independence Evaluations services must be performed by an OT with a valid Massachusetts license, or by either a certified Occupational Therapy assistant or an Occupational Therapy student under the direct supervision of a licensed OT.

Attachment A

Peer Support

Peer Support is designed to provide targeted recovery services to older adults with behavioral health diagnoses. Peer Support includes mentoring Consumers about self-advocacy and participation in the community, including, but not limited to, such activities as accessing a senior center, getting to medical appointments or a hospital for a medical procedure, assisting with care transitions, housing paperwork, accompanying for walks to various community locations, and generally engaging to reduce isolation. Peer support may be provided in small groups or one peer providing support to another peer (i.e., the Consumer). Peer Support promotes and assists the Consumer's ability to participate in self-advocacy. Peer Support utilizes trained peers as coaches who have lived experience of behavioral health challenges, trauma, and/or substance use to promote person-centered care and attainment of measurable personalized recovery goals. Peer Support encompasses a range of activities and interactions between people who share similar experiences of being diagnosed with behavioral health conditions, substance use disorders, or both. This mutuality, often called peerness between a Peer Support worker and person in or seeking recovery, promotes connection and inspires hope.

Transportation may be authorized and provided as a separate purchased service to assist with the Consumer's access to Peer Support services; the Certified Older Adult Peer Specialists (COAPS) may accompany the Consumer.

Peer Support can be an ongoing service provided it does not exceed 16 hours per week for the Consumer.

Peer Support must be provided through Peer Support Provider Agencies, including Peer Support Providers contracting with the Department of Mental Health, and individual Certified Older Adult Peer Specialists (COAPS).

Individuals providing Peer Support must have a Certificate of successful completion of Certified Older Adults Peer Specialist (COAPS) training. Peer Support Specialists are individuals who are 50 and older with personal experience of behavioral health challenges and/or substance use and who are in recovery. Certified Older Adult Peer Specialists (COAPS) provide hope, empowerment, choices and opportunities to older adults that promote behavioral health and substance use recovery in a supportive environment through shared experience.

Attachment A

Orientation and Mobility (O&M)

Orientation and Mobility (O&M) services teach an individual with vision impairment or legal blindness how to move or travel safely and independently in his/her home and community. This service includes: (a) an O&M assessment of an individual's needs; (b) training and education provided to Consumers; (c) environmental evaluations; (d) caregiver/direct care staff training on sensitivity to blindness/low vision; and, (e) information and resources on community living for persons with vision impairment or legal blindness. O&M Services are tailored to the individual's need and may extend beyond the home setting to other community settings as well as public transportation systems.

Individual providers and individuals employed by the agency providing O&M Services, known as Certified Orientation and Mobility Specialists, or COMS, must have a master's degree in special education with a specialty in orientation and mobility or a bachelor's degree with a certificate in orientation and mobility from an ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals) certified university program.

This service is available only to Consumers who are not eligible for O&M through the Massachusetts Commission for the Blind.

Attachment A

Transitional Assistance

Transitional Assistance Services are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for expenses associated with establishing and maintaining his or her own tenancy. Allowable expenses are those necessary to enable a person to establish a basic household and may include: (a) assistance with housing search and housing application processes; (b) security deposits that are required to obtain a lease on an apartment or home; (c) assistance arranging for and supporting the details of the move; (d) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (e) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (f) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (g) moving expenses; (h) necessary home accessibility adaptations; and, (i) activities to assess need, arrange for and procure needed resources related to personal household expenses, specialized medical equipment, or community services.

Transitional Assistance Services are provided only to the extent that they are reasonable and necessary as determined through the service plan development process, are clearly identified in the service plan, and the individual is unable to meet such expense or the services cannot be obtained from other sources. Transitional Assistance Services do not include room and board (i.e., monthly rental or mortgage expenses and food), regular utility charges, or household appliances or items that are intended for purely diversional/recreational purposes.

Transitional Assistance Services include only the non-recurring expenses described above incurred during the 180 days prior to discharge from a nursing facility or hospital, or another provider-operated living arrangement to a community living arrangement, or during the period following such a transition during which the individual is establishing his or her living arrangement. Transitional Assistance Services comprising home accessibility adaptations must be initiated during the 180 days prior to discharge.

Goods and services are reimbursable, care management is not reimbursable. No service is billable until the individual becomes a consumer. The care manager is responsible for working with the individual to develop a list of needs for transition and coordinating the purchase and delivery of goods and services. This coordination is part of care management, not Transitional Assistance. The ASAP pays individual providers, such as landlords, utility companies, service agencies, furniture stores, and other retail establishments for Transitional Services depending on the identified needs of the individual.