Continuum of Care: Developing a Seamless Network of Aging Services
In the past, most nursing homes functioned in isolation and were considered the preferred setting for the delivery of aging services. Now, a growing number of governing boards across the country are revisiting and widening their organizational mission, scope and customer base. These long term care (LTC) entities are either adding new services and levels of care internally, or forming partnerships with providers, government agencies and other human service organizations, in order to offer consumers greater choice.

The primary aim of an integrated model of service is to retain residents and clients over time through a spectrum of settings, including preventive, acute, transitional and skilled care. (See “Trend Toward Integrated Aging Services Gains Momentum,” page 4.) This continuum of care concept can potentially help your organization and consumers in many ways. Some of the benefits include:

- attracting prospective residents and families by offering a range of settings and service levels to meet changing needs
- enhancing residents’ independence and reducing their costs by placing individuals in the least acute level of care that can safely accommodate them
- increasing revenue by providing additional services within the bounds of the organization’s mission
- maintaining census by transitioning residents from one level of care to another with minimal disruption

The perceived advantages of this model have led many industry experts to consider seamless integration to be the wave of the future. However, the new relationships and responsibilities that occur with expansion or integration do not always develop without challenges and risks. Needlessly complex or poorly established networks can lead to increased administrative confusion and potential for error.

As these networks are still forming, no uniform model of integrated care currently exists. Still, some trends and directions have emerged, as more organizations work toward the goal of providing a true continuum of aging services. This edition of CareFully Speaking® is intended to guide readers through the early stages of integration, focusing on such key strategies as selecting appropriate enhancements, forming partnerships, facilitating intake and incorporating case management.
Identifying Community Needs

The essential first step toward providing a comprehensive network of aging services is to determine what pressing LTC needs are not being met within your operating region. Begin by soliciting input from the following local programs and institutions:

- charitable and advocacy groups
- churches, synagogues and other religious entities
- employee assistance programs
- home care providers
- municipal and county agencies on aging
- senior centers and residences
- social service organizations

As you assess area service offerings, bear in mind that most people – even those with chronic illnesses and serious health problems – prefer to live at home, if possible, supported by family, friends and other helpers. Therefore, expansion and integration plans often begin with intermediate support services, either in-home or community-based. These include the following programs, for which Medicare and Medicaid reimbursement is generally available in accordance with applicable regulatory parameters:

- adult day care: daytime supervision, activities, lunches and therapy
- chore assistance: errands, housekeeping and home maintenance
- diagnostic services: medical and x-ray laboratories
- home healthcare: in-home services by nurses, physical therapists and dieticians
- hospice care: palliative care for the terminally ill
- rehabilitation programs: physical, occupational, speech and respiratory therapy
- respite care: temporary relief for primary caregivers
- retirement housing: individual units, building security and social activities for independent elders
- senior centers: social activities, bus trips and tours

When building a continuum of care, adult day care, home care and hospice are among the more popular additions to a traditional menu of services. However, before offering these or other new options, you must evaluate your organization’s financial and human resources. A feasibility study can help you determine whether to provide the service yourself, or to link with a provider or agency at the local or regional level. (See “Common Areas of Expansion: What You Need to Know,” page 11, for some factors to consider before adding services.)
Trend Toward Integrated Aging Services Gains Momentum

Since passage and implementation of nursing home reform measures in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), the scope of care provided by the aging services industry has expanded. Today, a variety of settings delivers a large proportion of the nursing care once provided by hospitals. Populations also have expanded to include the frail elderly with more complex care needs, as well as a significant segment of younger, disabled or short-stay residents who require periods of recuperation and rehabilitation.

This growth has been paralleled by a change in the cultural philosophy underpinning the industry. Widespread adoption of such provider-led programs as the Eden Alternative, the Wellspring Initiative and the Pioneer Network has ushered in an era of resident-centered care. As the demand for consumer choice in care has intensified, organizations have sought to broaden their reach and diversify their service offerings.

Aging services are now defined to include extended sub-acute care, rehabilitative services, medical skilled nursing and supportive care services in the home, community or institution for individuals of all ages with severe chronic disability or significant functional impairment. This more comprehensive view of aging care has been adopted by such industry leaders as the American Association of Homes and Services for the Aging, American Association of Retired Persons, American Health Care Association and Healthcare Financial Management Association.

The federal government and many states have launched initiatives to remove barriers to participation in community-based services. These efforts include the following grants and programs:

- **The Date Certain Grant Initiative** helps states develop programs to encourage residents and their families to consider community- and home-based alternatives to nursing homes. To learn more about this federal grant program, visit [http://www.cms.hhs.gov/smdl/downloads/smd061998.pdf](http://www.cms.hhs.gov/smdl/downloads/smd061998.pdf).

- **The Medicaid 1915(c) Home and Community-Based Services (HCBS) Waiver** allows states to offer a waiver program covering both traditional medical services (e.g., dentistry, skilled nursing) and non-medical services (e.g., respite, case management, environmental modifications). Family members and friends may provide waiver services if they meet specified qualifications. To learn more, visit [http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp).

- **The New Freedom Initiative** permits states to offer home- and community-based services as an alternative to institutional care for disabled persons who are eligible for nursing homes. To learn more, visit [http://www.hhs.gov/newfreedom/init.html](http://www.hhs.gov/newfreedom/init.html).


- **Real Choice Systems Change (RCSC) Grants** aim at improving support systems for children and adults who have a disability or long-term illness. To learn more, visit [http://www.cms.hhs.gov/RealChoice/downloads/RCSC2007_SolicitationFinal.pdf](http://www.cms.hhs.gov/RealChoice/downloads/RCSC2007_SolicitationFinal.pdf). In support of the RCSC implementation, the Centers for Medicare and Medicaid Services launched the Community Living Exchange Collaborative (known as The Exchange), which provides information, training and technical assistance for more than 180 recipients of Systems Change Grants for Community Living. For more information, visit the Web site of the Home and Community-Based Resources network at [http://www.hcbs.org](http://www.hcbs.org).
Should you opt to provide new services through a partnership agreement rather than internal expansion, you may wish to review the Social Accountability Program (SAP), created by the American Association of Homes and Services for the Aging (AAHSA). This document is designed to help organizations select and implement community partnerships suited to their governing mission and capabilities, as well as community needs. Although the SAP is aimed primarily at tax-exempt organizations, it also may be a good resource for for-profit facilities evolving toward integrated care. The second edition of the SAP, subtitled “The Community Benefit Tradition of Not-for-Profit Homes and Services for the Aging,” is available at www.aahsa.org.

Partnering with Outside Providers

Before considering a contractual relationship with a provider of home care, hospice, durable medical equipment (DME) or other services, it is necessary to scrutinize both the strengths and weaknesses of the other organization and the proposed agreement itself.

Due diligence. In the context of business negotiations, due diligence refers to the duty of each party to confirm contractual expectations and to verify the other party’s ability to satisfy the terms of the agreement before it is executed. Aspects of the other organization that must be carefully researched and documented include

- clinical practices and procedures
- financial resources and solvency
- networking ability
- range of products and services
- staffing level and qualifications

Negotiations. As it requires a significant investment of time to perform due diligence and to achieve mutual understanding of goals and expectations, negotiations should not be hurried. To avoid a poorly drafted contract and resulting conflicts, forgo any decisions until senior management and legal counsel have reviewed all relevant documents and information, including

- comparison data from similar providers
- cost of care
- credentialing and privileging of mid-level providers and physicians (if applicable)
- historical claims data
- licensing, certification and accreditation status
- measurable quality standards
- readiness for expansion
- reporting of professional liability claims or lawsuits
- resident/client volume
- risk and quality management, including performance improvement plans and protocols
- staff education efforts regarding safety, equipment usage and infection control

**Liability.** It is essential to determine whether existing insurance coverage and liability limits are sufficient in light of expanded services and associated exposures. The following questions can help clarify basic insurance and liability issues:

- **Does current product liability insurance adequately cover new contracts involving DME?**
- **How will workers’ compensation and automobile liability exposures be covered under the agreement?**
- **If a new legal entity or name exists, are all parties notified of the change, and is the name reflected on relevant contracts, leases and policies?**
- **Is the entity covered for third-party crime, especially in home and day care settings?**
- **Who has administrative responsibility and legal control of the expanded entity and its employees?**

**Contract review.** Consult legal counsel to ensure that agreements with providers and other organizations contain all necessary protective provisions. Primary elements of a well-drafted contract include

- access to accounting records
- amendment process
- applicable state law
- effective date
- indemnification and hold harmless provisions
- insurance requirements
- legal names of the parties
- licensing, certification and accreditation requirements
- payment terms
- performance expectations
- remedies for breach of contract
- signatures of appropriate parties
- termination date

A comprehensive discussion of contract review is beyond the scope of this article. For more information, see *inBrief®,* 2006 – Issue 2, “Fundamentals of Contract Review,” available at [www.cna.com](http://www.cna.com).
Streamlining Administration

Creating an expanded network of care options can lead to administrative complexities. The following strategies can help minimize inefficiencies and the potential for redundant practices:

*Adopt appropriate technology.* To encourage initial contacts, consider creating a Web-based information system (complemented by a central telephone number) to link service counselors with physicians, acute care providers and neighborhood senior resource centers. Electronic access allows wider outreach and also empowers providers, residents/clients and families to take the first step in learning about your facility.

*Consolidate entry.* For maximum efficiency, there should be a single point of contact and entry for all prospective residents/clients, regardless of where they are located in the continuum of care. Consolidating multiple points of admission into one intake unit can improve needs assessment, assistance planning and program referral.

*Develop multidisciplinary teams.* To facilitate entry, counselors should have easy access to a multidisciplinary team with expertise in geriatric and disability care, social work, and benefit analysis. This team will then help determine the appropriate type, level and setting of care for individual applicants.

*Assign specialized advocates.* Some organizations have trained professionals to advocate on behalf of certain groups, such as the frail elderly, disabled adults or impaired younger persons. By focusing on a specific population of potential residents/clients, these specialists can enhance coordination of services among partnering organizations via care conferences, round tables and working groups.

Coordinating the Assessment Process

The assessment process in a continuum of care model emphasizes matching the needs of a prospective resident/client with available resources. However, processes currently in place may be disjointed, with a medical team evaluating a resident’s physical needs upon admission, a social worker independently examining entitlement to services, and other staff members conducting possibly redundant assessments. Below are some guidelines designed to consolidate the entry process, identify and document more useful information, improve access to data and lessen the likelihood of placement error.

*Develop and implement consistent assessment procedures.* Standardized evaluation formats and question protocols allow for a more thorough and reliable application process.

*Capture a balanced range of information.* An assessment that considers only medical requirements can tilt the placement process toward skilled care – even when less expensive and constraining settings may be appropriate. For this reason, the intake process should gather information about a range of medical, psychological and social factors that can affect placement.
Screen for risk factors. Begin with a general risk factor evaluation designed to identify those who would benefit from facility-based care, rather than comprehensive home-based or community care. Have a social worker or registered nurse with specialized training and experience in geriatrics conduct an interview that focuses on the following questions:

- **Are any progressive disease processes in evidence**, such as diabetes, osteoporosis, pulmonary disease or end-stage renal disease?
- **Does the client have Alzheimer’s disease** or any other debilitating condition that causes deterioration of self-care skills?
- **Has the client suffered from a catastrophic illness**, multiple trauma or amputation, or been diagnosed with multiple sclerosis, stroke, AIDS, neurological disease, cancer or birth defects?
- **Are there any special health needs**, such as rehabilitation from illness or surgery, restorative services, tube feeding and/or monitoring with special equipment?
- **Has the client undergone multiple hospital admissions** within the past six months?
- **Have there been previous nursing home admissions** within the past two years?

Evaluate the client’s medical status. A medical assessment by a licensed physician trained in geriatric and disability care should follow the initial series of screenings. Your assessment format should be standardized to ensure compilation of these critical findings, among others:

- behavioral evaluation
- functional status
- history and physical
- medication review
- mental status
- nutritional evaluation
- review of alternative therapies
- review of rehabilitation status
- substance abuse evaluation

Inquire about other needs, resources and values. Include queries about the following areas, among others, to obtain a better understanding of the situation and requirements of the client/resident, and to facilitate appropriate placement:

- employment situation
- equipment and home modification needs
- formal and informal support systems
- housing and neighborhood conditions
- income and finances
- language and cultural issues
- potential for physical and financial abuse
- values, including religious and moral beliefs

Document findings for easy access. To ensure proper coordination of effort, the results of all resident/client assessments must be effectively documented and conveyed to administrators, counselors and clinical staff. By enabling electronic access to data, you can expedite review of intake information and enhance communication with residents/clients and families.

**Utilizing Case Management**

Case managers coordinate between the LTC organization and hospitals, community agencies and other providers of aging services. An effective case management program supports an integrated care delivery system by

- **counseling clients** on the range of available options, resources and benefits
- **promoting consumer choice**, thereby fostering competition among providers
- **encouraging collaboration** between agencies, providers and institutions
- **facilitating user-specific services** among targeted resident/client groups
- **documenting resident/client expenditures** and reducing misappropriation of cash allowances

Following an intake and needs assessment, a case manager should be assigned to follow the resident/client from initial contact onwards, and to serve as an advisor and information source for the resident/client and family.

In general, case managers should have a professional background, preferably in nursing or social work. This experience helps them navigate a complex, multi-agency system and act as effective client advocates. They should also possess a working knowledge of consumer-directed care options, including personal budgets and other funding vehicles.
Minimizing Risk

An expanded menu of services within an integrated setting can translate into heightened liability exposure. To protect your facility against litigation, implement policies and procedures that reflect the following preventive risk management principles:

- **Identify the parameters of care** that affiliated settings or services are licensed to provide and focus all interventions and programs around existing capabilities.

- **Establish customary practices for each setting or service** – including procedures for admission, monitoring, program/service evaluations and discharge – based upon the level of acuity of the resident/client. Make this information readily available to all residents/clients.

- **Screen all potential home healthcare clients** in their home environment and take the opportunity to identify hazards.

- **Develop a written plan** for all residents/clients that specifies the scope, frequency and duration of services.

- **Report any changes in resident/client behavior and physical condition** promptly and arrange for medical evaluation. These observations may indicate the need for intervention or a higher level of care.

- **Negotiate a shared-risk agreement** if the resident/client refuses to comply with the agreed-upon service plan or engages in risky behavior. The agreement, which should be developed with legal counsel, should never be used to retain a resident/client whose needs are beyond the scope of care provided in a given setting.

- **Partner only with services, agencies and providers that you trust and respect.** Ensure that contracts are reviewed by an attorney and that they articulate mutually satisfactory goals, lines of authority and decision-making power.

Forming an integrated delivery system requires a significant investment of time and resources. The potential benefits of such a shift include enhanced resident/client satisfaction, increased census and length of stay, more efficient utilization of capabilities and greater long-term stability in a competitive marketplace. To maximize these benefits and minimize risk, it is necessary for organizational leadership to implement sound policies and procedures that cross institutional boundaries. Such protocols will enable expanded organizations and partnerships to provide a continuum of quality, individualized care.
ADULT DAY CARE

Scope of Services
Working in coordination with other community resources, adult day care (ADC) programs offer a range of services to disabled, frail or at-risk adults, including recreational activities, health monitoring and respite for caregivers. Many organizations have added an ADC component or have partnered with ADC providers in their community, allowing residents/clients the opportunity to spend time during the day at the adult day care center and return at night to the facility or their home.

Benefits
A facility-sponsored or affiliated ADC program
- **fosters continued independence** for residents in a stimulating, well-monitored environment
- **allows expansion** of services with relatively low investment
- **generates awareness** of your organization among ADC clients and families

Planning Considerations
1. **Define your client base,** including demographic segment, special needs capabilities (e.g., incontinence, dementia, dietary restrictions) and service region.

2. **Develop contacts** in the adult day service community by joining appropriate associations, such as the National Adult Day Services Association (NADSA), at [http://www.nadsa.org/](http://www.nadsa.org/). Market your program through in-service training seminars and presentations to community groups.

3. **Incorporate established standards and guidelines,** such as those promulgated by NADSA. By adhering strictly to federal and state regulations, you can reduce liability risk while maximizing government funding.

4. **Research funding sources.** Successful programs often rely on a combination of private and public revenue sources, including federal food, subsidized senior employment, developmentally disabled and aging programs, as well as grants from endowed foundations.

5. **Develop and implement written policies** covering these essential areas, among others: admission criteria, discharge procedure, client bill of rights, confidentiality and release of information, emergency and evacuation procedures, and personnel issues.

6. **Keep daily logs** documenting attendance, transportation and meal counts.

7. **Prepare client files** containing the following information: intake assessment, physician’s approval of participation, permission for emergency medical care, case management notes and annual care plans.

8. **Maintain appropriate staffing levels.** Personnel should include a director, program assistants, secretaries, drivers and driver aides, and housekeeping personnel. Aim for a safe staffing ratio – generally considered to be one program assistant for every six to eight clients.

9. **Determine your transportation policy,** i.e., whether driving will be the responsibility of staff members or contracted vendors. In either case, prepare daily transportation logs and know how to contact drivers at all times. Ensure that vehicles accommodate wheelchair-dependent clients, and that drivers have access to clients’ medical and emergency information.

10. **Offer clients a variety of activities** that will challenge them while providing a feeling of success and accomplishment. Activities should accommodate conditions ranging from dementia to aphasia to varied levels of physical functioning.
Planning Considerations

1. Revisit your organization’s statement regarding end-of-life philosophy and ensure that it is consistent with residents’ wishes, relevant standards of care and statutes regarding end-of-life decision-making. Document each resident’s choices in this area.

2. Thoroughly review Medicare’s hospice benefit, including conditions of participation, levels of care, coordination of care and reimbursement.

3. Determine whether you have the human, financial and clinical resources to provide a comprehensive panel of palliative care services, including
   - bereavement care
   - chemotherapy and radiation for palliation
   - hydration and nutrition
   - medications, equipment and supplies related to terminal conditions
   - pain and symptom management
   - social and spiritual guidance
   - speech, physical and occupational therapy support
   - wound care and consulting

4. Adopt appropriate palliative care protocols for common clinical occurrences, such as pain, dehydration and constipation. Base protocol development on the Clinical Practice Guidelines for Quality Palliative Care, as endorsed by the National Quality Forum. The guidelines are available for viewing at http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=5058.

5. Maintain staffing levels sufficient to meet the complex care needs of a dying resident and to assist in managing the psychosocial issues of the resident and family.

6. If you choose to contract with hospice providers for services, first obtain answers to the following risk-related questions, among others:
   - What is the scope of services?
   - Is the program accredited?
   - How long has the provider been in business?
   - Are hospice home care workers licensed and bonded?
   - How is staff trained?
   - How are competencies and skills measured?
   - How will quality of care be monitored?
   - Are services provided for children?
   - What confidentiality provisions exist to protect client privacy?
   - Which party is responsible for equipment maintenance and repair?
Planning Considerations
1. Carefully review insurance coverage. Become conversant with the definitions and levels of care approved by health plans, Medicare/Medicaid and other coverage sources.

2. Integrate the treatment plan by developing care plans for common diagnoses. Plans should minimally include standing physician orders, outcome indicators, critical pathways and pharmaceutical management.

3. Continually assess the use of resources. By communicating regularly with case managers about client needs and utilizing a standard reporting format, you are in a better position to justify higher levels of care, when indicated.

4. Document clients’ level of comprehension by testing their knowledge of indicators and instructions, and having them demonstrate self-treatment skills.

5. Emphasize changes in condition when sending case reports to primary care providers and physicians.

6. Notify clients in writing of substitutions in care providers and document the client’s consent, which will help maintain good client relations and reduce the threat of abandonment claims. In addition, develop an emergency protocol in case a provider fails to make an assigned visit, and be prepared to implement the protocol.

7. Establish a written policy defining when client requirements exceed the scope of home care capabilities. Prepare a written protocol for terminating care and include measures to ensure transfer to a skilled or acute care setting.

8. Require legal counsel to review contracts. Ensure that agreements between your organization and clients delineate basic rights, responsibilities and expectations, including how and when termination of services can occur.

9. Develop a risk management program addressing relatively common hazards, including the following:
   - abandonment allegations following termination of services
   - abuse of clients by caregivers
   - complications from home infusion therapy
   - mishaps involving durable medical equipment
   - noncompliance by clients or caregivers
   - prolongation of home services to clients who require a higher level of care
   - theft by home care staff
Resources: Organizations

- Administration on Aging (AoA), under the U.S. Department of Health & Human Services, at [http://www.aoa.gov/](http://www.aoa.gov/), provides information on a wide variety of federal programs that offer services and opportunities for older Americans and their caregivers.

- American Association of Homes and Services for the Aging (AAHSA), at [http://www.aahsa.org](http://www.aahsa.org), is a coalition of not-for-profit organizations dedicated to offering a continuum of aging services, including adult day services, home health, community services, senior housing, assisted living residences, continuing care retirement communities and nursing homes.

- Assisted Living Federation of America (ALFA), at [http://www.alfa.org/](http://www.alfa.org/), is the largest national association exclusively dedicated to professionally operated assisted living communities.

- Center for Aging Services Technologies (CAST), at [http://www.agingtech.org/index.aspx](http://www.agingtech.org/index.aspx), is dedicated to the development, evaluation and adoption of emerging technologies that can improve the aging experience.

- Center for Home Care Policy & Research, at [http://www.vnsny.org/research/](http://www.vnsny.org/research/), conducts research to promote the delivery of high-quality, cost-effective care in the home and community, and to support informed decision-making by government, payers, managers, practitioners, and consumers of home- and community-based services.

- Home Care Research Initiative, at [http://www.vnsny.org/hcri/index.html](http://www.vnsny.org/hcri/index.html), is a program of the Robert Wood Johnson Foundation and the Visiting Nurse Service of New York. Its goal is to better allocate home and community care dollars, target services to those most likely to benefit, and improve service efficiency.

- Hospice Foundation of America (HFA), at [http://www.hospicefoundation.org/](http://www.hospicefoundation.org/), provides leadership in the development and application of hospice, with the goal of enhancing the American healthcare system and the role of hospice within it.
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Resources: Readings