ANCOR
American Network of Community Options and Resources
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October 18, 2017

Att: Isabelle Leventhal
Council on Accreditation
45 Broadway, 29th Floor
New York, NY 10006
ileventhal@coanet.org

Re: Comments to COA Adult Foster Care Standards Draft

Dear Ms. Leventhal,

The American Network of Community Options and Resources (ANCOR) is a national trade association based in the Washington, DC area representing over 1,400 private providers of community disability services around the country. Our members primarily serve adults with intellectual and developmental disabilities (I/DD) who were either born with a disability or acquired it during their childhood development (e.g., before the age of 21). The vast majority of the services our members provide are funded by the Medicaid program and are provided through either a state plan/waiver or 1115 demonstration.

The adult foster care (AFC) program is an important service for many of our members who want to ensure that people with disabilities can return or remain in the community and live independent lives, but issues like the affordable housing options or support staff workforce shortages are presenting challenges in offering a spectrum of service settings/options. AFC is an exceptional service, supporting persons with I/DD whom want to live in a home and neighborhood of their choice, and most importantly enjoy the natural rhythms of a family lifestyle. ANCOR is pleased that the COA has put out draft standards and hope our input serves to be of value.

ANCOR brought together experts from our membership to compile input on the standards. Please see below the key areas of our comments followed by a short addendum which expands upon some key items.

I. Definition of AFC

In the I/DD field and likely in others, we believe it would be necessary to better define adult foster care. For instance, we view adult foster care services as a piece of a larger growing innovation of shared living. We typically would refer to adult foster care as a situation where a person with a disability or a person who was elderly receives services and resides in the home of a caregiver/provider.

When the service is being offered in the home of the person served (as service recipient), we typically refer to this as in-home supports, supported living, live-in model, or a paid roommate setup. We feel that is an important distinction because the standards and expectations differ between these scenarios. We are hoping that for purposes of these standards, we can define adult foster care services as those services and supports that are provided to a person in the caregiver/provider's home.

Additionally, we wanted to share that in the provision of adult foster care in our services and supports, where many of the adults with I/DD may be under the age of 65, there may be circumstances where the AFC services wanted and needed are not exclusively long term. In some cases, persons are receiving short term AFC services to meet unexpected, temporary, or transitional needs. We hope this can be included in the definition as well, rather than just referencing long term services and supports.

Also, we recommend that there be further clarity within the defined population, which is currently noted as "adults who are in need of long term services and supports due to a number of conditions that affect their mental or physical condition including: behavioral symptomatology, age-related concerns, and loss of functioning at end stage illnesses." Generally in the I/DD field we have steered away from terminology around "conditions" and may use "disability" or "impairment" when necessary.

We also questioned whether alcohol and drug dependencies would be included under this definition (behavioral symptomology) or whether the intention was to be more specific to the disability and aging community (our preference).

II. Qualifying Caregivers/Providers and Matching Persons Referred for Services/Supports

We recommend more detailed standards on the qualifying and matching of persons served with caregivers as AFC providers, particularly since this is key to a successful outcomes. In Addendum A to this document, we provide some more in depth of examples of qualification standards that should be in place to assure that placements and matching of persons is being done in the most thoughtful and careful way possible. (See Addendum A at end of this document)

III. Qualifying AFC Environments

With the current standards we felt some were still too broad. For instance, what does having an adequate kitchen mean? What is adequate heating, lighting, water supply and ventilation? Pennsylvania's regulations in Chapter 6500 of their Family Living Home regulations (attached to our submission) are a good example of deeper requirements for the expectations that States should have around living environments and safety, communicating these

expectations at the outset to AFC caregivers/providers. We would also note that the Center for Medicare and Medicaid Services' (CMS) HCBS Settings Rule would likely cover several types of adult foster care settings and that those components would have to be in place in many of these services, both for the IDD and aging populations.

IV. Service Plans and Person-Centered Planning

a. Transition Plans and Backup Plans

We feel it is essential that the service plan includes a transition plan as a proactive measure should the caregiver/provider no longer be able to offer the AFC service to the person. Additionally, also to include a backup plan to allow the caregiver/provider to have planned breaks or respite or tend to unplanned family or personal emergencies. Our members have found having a transition and backup plan clearly detailed in the service plan has generally been a successful method.

b. Increased Risk

The service plan should also address case by case situations where there may be increased risk to the caregiver/provider, the household occupants, and the person served. For instance, it should seek to address expectations around visitors to the AFC home so that both parties have a clear understanding of these scenarios and potential risks.

c. Addressing Changes in Plan

The persons being served by our members range in age and have constant fluctuations in service and supports needs as they age, circumstances change, current physical/mental disabilities advance, etc. There should be a clear plan for how to address such changes in the person's service plan. This includes scenarios like when a person's medical or other specialist services change in location, accessibility, or frequency. (e.g.; medical specialist visits were 10 miles away but with changes are now 60 miles away, once a month appointments are now needed once a week) – any preplanning on process for how to address these scenarios will be helpful as the needs of the person change and the service plan evolves.

d. Person-Centered Planning

In the I/DD field, person-centered planning is a legal requirement but also important component of creating a comprehensive and meaningful service plan across all service settings. Using person first language ("a person who is deaf" rather than "deaf person") and also ensuring that that a service plan is written, communicated, and developed in a respectful manner, valuing the person over their disability or limitation. Also, the involvement of natural supports (e.g., family, friends, etc.) can be very important, however the person being served should select who they want, and don't want to participate in their support plan or meetings- under person-centered planning rules.

V. Budgetary Standards

COA's draft standards have several sections on personnel expectations under AFC 11 including educational and background requirements as well as coverage of service hours. While we support the standards themselves, we are concerned that there are no budget standards to compliment them. Standards on the expectation of payment coverage for room and board and clarification of who pays for what (e.g., Is the standard that the person served pay for food? Does the caregiver/provider?), as well as a statement of supporting adequate provider payments would be helpful.

VI. Community Life Standards

The COA draft standards speak more to the medical care component than to community and a meaningful everyday life. Particularly because we serve persons with intellectual and developmental disabilities throughout their lifespan, we want to be sure that the community life piece well represented and included within the standards. ANCOR is happy to work with COA on language and standards that would reference the CMS HCBS Settings Rule themes of ensuring that a person has full access to the benefits of community living and the opportunity to receive services in the most integrated setting possible. Our members felt that some caregivers/providers may not have the expectation of providing this component at the outset so that it would be helpful to insert in standards.

VII. Insurance

Our members who help to administrate the services that AFC caregivers provide usually require or provide some type of liability insurance to the caregiver/provider under their agency. This may be an important consideration for establishing standards of protection for caregivers/providers.

VIII. Legal Guardian Language

Legal guardianship is referenced in the COA draft standards and we would recommend changing it to "legal representative" because there are several legal representative relationships outside a guardianship that may serve to be helpful in establishing adult foster care services (such as a person who does not have court appointed guardianship, but may have been appointed Power of Attorney by a family member or other representative).

IX. Quality Assessment (AFC 10)

AFC 10 under the draft standards that covers case closing does not seem to address quality assessment and customer satisfaction. It is very helpful, especially when closing a case, to determine if the AFC placement and services was successful, whether it was a good match for the person and why/why not, and whether it would be a good placement for a future person or

whether that depended on their specific service and support needs. The case closing is a key opportunity to gather this information. One framework to consider is that of National Core Indicators which seek to measure the outcomes of community services for people with I/DD around the country. Although there would be some different indicators for adult foster care, the general theme of whether the service was successful and the person was served well, is consistent.

Thank you for the opportunity to submit these comments. Should you have any questions, please do not hesitate to reach out to me.

Sincerely,

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ADDENDUM A (Qualification of Caregivers/Providers) – Selected Criteria from Mixed Sources:

Caregivers/providers are at least 21 years of age.

Background investigations are completed for all household members age 18 or older, unless otherwise required by state law or regulation. Background checks include:

- Criminal background check; and
- Child and Adult Protective Service checks.

A minimum of three written (non-relative) references are obtained for anyone applying to provide care as an AFC caregiver/provider.

A health status statement, signed by a licensed health care professional, is obtained for the caregiver/provider.

All pets in the home have up-to-date vaccinations and licenses, as appropriate.

A comprehensive home evaluation is completed.

- An assessment of the home and caregiver/provider, including his/her ability to provide a therapeutic and safe environment for the person receiving supports and services;
- The safety and appropriateness of the physical environment of the home as measured by state laws, regulations, etc.;

- The criminal and juvenile delinquency histories of all household members, including children/youth under the age of 18;

- Regular visitors have had the required background checks in compliance with all applicable licensing standards and state regulations;

- The relationships among AFC caregiver/family members, including adult children who may not reside in the home, and their ability to provide the person referred for services with a stable and nurturing environment; and

- The ability of all members of the AFC caregiver/family household to understand and implement adult foster care model of service.

Copies of driver's licenses are obtained for all persons authorized to provide transportation for the person.

The caregiver/provider's vehicle is properly insured with coverage in accordance with State law.

If the caregiver/provider does not use an automobile for transportation, he/she has access to public transportation and/or to a licensed driver who meets the above requirements.

Also:

Matches are made after careful consideration of the compatibility between the referred person's needs and the characteristics of the caregiver/provider and their household composition. The following factors are considered in making a match:

- The person's cultural, ethnic and racial background is considered, as well as the caregiver/provider's capacity to meet the needs of a person of this background. These factors are considered in conjunction with other factors relevant to the person's best interests and are not used in a manner that delays or denies placement.

- If placement with a caregiver/provider of the same race/culture is not possible, or is not preferred by the referred person, then placement in a community, which is inclusive of the person's racial/cultural group, may be acceptable. In any circumstance where a person is placed outside his or her racial/cultural group, caregiver/provider is provided with information to familiarize them with the person's cultural needs and preferences. As applicable, the person's legal representative must concur with the suitability of the AFC placement.

- Proximity to the person's family and community to the new home is considered in making a match. Continuation of significant relationships (school, recreational programs, co-workers, physicians, friends and family) is supported as appropriate.

When maintaining a person's ties to his or her community is not indicated or permitted by the referral source or when providing services in the person's home community is not possible, consideration is given to securing a home where the special interests or needs of the person can be supported. Such special needs might include proximity to a hospital with specialized services, availability of vocational programs, recreational/sports and/or cultural activities.

In programs providing services and supports to juvenile or adult offenders in adult foster care setting, potential homes will be assessed for appropriateness given the person's presenting behaviors and identified risks.

Special consideration is given to the composition of the placement/family and the identified risk issues presented by the person being considered for placement. The number of persons in the provider/family home, their ages, gender, and stage of development are evaluated in light of the person's level of functioning and ability to relate to others.

Placements of persons who have a documented history of sexually inappropriate behavior or sexual abuse require that careful consideration be given to the age, gender and vulnerability of caregiver/provider's children or other vulnerable persons who regularly visit the AFC home.

The experience, background, competency, strengths and skills of the caregiver/provider and their family/household composition are assessed in relation to the person's needs.

If the caregiver/provider AFC home has a swimming pool, the person's ability to swim and his/her capacity to comply with pool safety rules are considered when making the match.

Unless prohibited by regulation, caregiver/providers that are identified for potential matches are required to read the referral information prior to making the decision to accept a placement.

- Designated program staff provides information to the caregiver/provider concerning the person to be placed in their AFC home.

- This review includes, but is not limited to, the person's history, his or her clinical needs, the requirements of the anticipated service plan, the person's strengths and limitations and his or her documented behavioral and/or medical needs. Anticipated intervention strategies are discussed in detail at this time.

Members of the caregiver/provider's family must indicate a willingness to accommodate the person who is being considered for placement. The caregiver and their family's review of confidential information are documented.

Reasonable effort is made to maintain consistency of AFC caregiver/provider's for persons receiving supports and services. If it is necessary to change caregivers/providers, the matching process is implemented to identify a new AFC placement/caregiver. A transition plan is developed to introduce the new caregiver/provider, and transfer information and minimize disruption to the person served.