Department of Health & Human Services, Centers for Medicare & Medicaid Services

Emerging LTSS Issues in Indian Country:
Adult Family Homes

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Introduction

The American Indian and Alaska Native (AI/AN) elder population is projected to double by the year 2030 (Centers for Medicare & Medicaid Services (CMS), 2016). The AI/AN population currently faces many issues, such as poor nutrition, obesity, substance use disorders, violence, and injuries that deteriorate health conditions over time (Kitzes, 2002; Arenella et al., 2010; Marr, Kitzes, Neale, & Wolfe, 2012; Portman and Garrett, 2006; National Cancer Institute, 2011). Subsequent chronic disease and other comorbid health issues, combined with access to care often delayed by geographic isolation, poverty, and a lack of insurance support, result in many elder AI/ANs needing 24-hour care (Finke, Bowannie, & Kitzes, 2004; Hampton, 2005; Indian Health Service, 2006; Kitzes, 2003; Arenella et al., 2010). Often, skilled nursing homes are looked at to provide the long-term, round-the-clock care needed by elders. However, these types of facilities may be located great distances from elders' homes, forcing them to leave families, communities, and lifestyles to receive necessary health support and services. Because Native communities do not operate them, these facilities may often lack culturally sensitive tools and protocols when caring for elder AI/ANs and their families. This contributes to Native elders experiencing high rates of loneliness, alienation, and isolation in these facilities (Branch, 2010).

Many tribes are working to develop programs that address these concerns and allow elders to stay in their communities. One such option is home- and community-based services (HCBS). HCBS includes a menu of in-home services, community services, case management, transportation, and other services that are needed to support elders who wish to receive care in their community. This document reviews one such HCBS care option: Adult Family Homes (AFHs). AFHs enable tribes to develop care models in tribal communities with smaller elder populations that are located great distances from the nearest care facility, and have few resources to construct new facilities.

Background

Community Residential Homes (CRHs) fall under the umbrella of HCBS that describe a cost-effective array of living options that include AFHs (also known as adult foster homes or board and care), as well as adult residential care, assisted living, and small-scale living (McCurry, LaFazia, Pike, Logsdon, & Teri, 2012; Hedrick et al., 2003; Curtis, Sales, Sullivan, Gray, & Hedrick, 2005). CRHs are considerably smaller than institutions like nursing homes, caring for fewer than 15 individuals in a home-like environment and preserving resident self-sufficiency by supporting their personal care and other needs. CRHs offer a care option for families whose loved one's care demands are beyond what the family can provide at home, but who wish to continue to keep their family member in the community (Janicki, Dalton, McCallion, Baxley, & Zendell, 2005).

It is important to understand that a CRH is not a replacement for nursing home care. For rehabilitation after a surgery; treatment for an illness requiring ongoing daily nursing care; or for recovery from an illness requiring multiple treatments, procedures, and complex medication regimens, a skilled nursing facility is an appropriate place for an individual to receive care. However, for long-term support with

activities of daily living or for assistance with transportation, behavior management, or individualized support, a CRH is an appropriate way to provide care.

It is also important to understand that a CRH is *not* a transitional care location. For example, an elder will not "age out" of the care in a small facility or "graduate" to a skilled facility. When an elder's care needs increase, the staff receives the necessary training to tend to those needs or other support is connected with the elder to continue the provision of enhanced care in the community. Properly managed, elders appropriately receive assistance in a small residential facility for as long as they choose or need to receive care. If the elder needing care is Medicaid-eligible, communication with their case manager can assure that additional necessary services are provided using Medicaid funds.

Although specific definitions, requirements, and names for these small facilities vary by state, AFHs are generally licensed residential homes that assist two to six residents with personal care tasks (Sales et al., 2005). These homes provide 24-hour, person-centered care; room and board; and, often, specialized care for elders with dementia or mental health needs (McCurry et al., 2012). AFH owners may provide care directly, hire caregivers to provide the care, or do a combination of both.

AFHs also offer tribes an attractive alternative to skilled nursing care by allowing substantial support for elders on a smaller scale and with fewer regulations than nursing homes (Sales et al., 2005; Curtis et al. 2005). The AFH model is flexible, home-like, and requires minimal start-up funds if using an existing individual home for the physical location. For a tribal community that has few resources, a small elder population, or is located a great distance from the nearest long-term care facility, an AFH offers an option for LTSS services to be developed in their community to provide individualized care and keep elders close to family and friends.

AFH Considerations in Indian Country

An AFH is are an ideal long-term care option for tribal communities located great distances from the nearest facility, with community members in need of long-term care, but not enough to warrant the construction and operation of an entire facility, and that wish to keep their tribal members in the community. The process to develop an AFH has a number of factors that need to be considered before implementation to ensure the model fits the community. These factors include reviewing and considering state regulations, resident funding options, operation costs, staff training, and community need.

Review of State Regulations

State regulations outline the requirements for AFH operation and have specific qualifications regarding staffing, training, resident capacity, physical structure of the building, and other components that affect operations (McCurry et al., 2012; Bahora & Reno, personal communication, March 16, 2016). These standards can be particularly significant for homes that provide care to individuals with dementia and/or behavioral health diagnoses that face additional standards for staff and training (Janicki et al., 2005).

Adhering to the AFH state license process requires specific resources from a tribe—tribal community and tribal council support, an advocate to manage the process, and liaisons in the state agency issuing licenses (Zylstra, personal communication, March 14, 2016). Additional resource needs vary, as regulations are often unique to the particular state in which the AFH is located. Table 1 lists a few examples of state regulations for AFHs in Florida, Idaho, Washington, and Wisconsin, and highlights varying expectations across regions.

Table 1: Comparison of Sample State Regulations for Adult Family Homes

	Florida	Idaho	Washington	Wisconsin
Name of Program	Adult Family-Care Home	Certified Family Home	Adult Family Home	Adult Family Home
Home Capacity	5 adults	1–2 adults; waiver available to increase capacity to 3–4 adults	6 adults	3–4 adults
Daily Living Activities	bathing, dressing, eating, grooming, toileting, and ambulation	bathing, dressing, eating, grooming, toileting, ambulation, communication, and money management	bathing, dressing, eating, grooming, toileting, and ambulation	bathing, dressing, eating, grooming, toileting, ambulation, object manipulation, and rest
Caregiver Training	First Aid and CPR, fire and food safety; 12 hours basic training and 3 hours of continuing education (CE)	First Aid and CPR, fire and food safety; 8 hours of CE	First Aid and CPR, fire and food safety; 1,000 hours of direct care experience	First Aid and CPR, fire and food safety; 15 hours basic training; 8 hours of CE
Home Site Standards	home-like environment; 40 sq. ft. for common space or each room at least 60 sq. ft.	home-like environment; many fire and safety specifications	home-like environment and other requirements	home-like environment; maintain 74 degrees Fahrenheit
Tribal-Specific	No	No	state may pay for resident services if eligible AFH is on tribal land	No

Resident Funding Options

The cost of providing room and board; assistance with activities of daily living, and support for transportation, social engagement, and personal assistance may be covered in a variety of ways. Having

a mix of different payment types for services can be helpful, but can also make business planning more difficult. Payment for room and board is covered through a variety of funding streams; common options include private pay, long-term care insurance, and Medicaid.

Medicaid is a common funding source for elders who are low income and need long-term care; however, the following should be considered when working with states to seek Medicaid certification to provide services under Medicaid waivers:

- State Medicaid rates for CRH are substantially lower than the reimbursement rates for skilled nursing facilities.
- Medicaid waivers and reimbursement rates for HCBS varies from state to state and will vary within states based on the care needs of the clients.
- Medicaid waivers vary tremendously from state to state; however, in some states, additional services may be allowed in a CRH as ancillary services (nutritional counseling, environmental modifications, behavior management). If the tribe also contracts for these services, there will be additional reimbursement available to the community.
- Medicaid certification process, required record-keeping, and review can be a challenge for providers (Zylstra, personal communication, March 14, 2016; Bahora & Reno, personal communication, March 16, 2016; Sales et al., 2005).

Cost of Operation

The cost of operating an AFH is relatively low compared to other types of long-term care facilities (e.g., nursing homes). AFHs generally have fewer residents, require less staff, have a lower demand for rehabilitative care, and have less medical equipment costs. That said, AFHs that decide to specialize in care for elders with dementia or behavioral health issues may require more staff, training, or home modifications. Larger facilities that often require new construction have huge overhead costs that demand a certain capacity point to offset operating costs. AFHs, in contrast, can successfully function with an average of two to three residents in structures that already exist and may only require a few modifications. Also, if the AFH ever loses its cost effectiveness or becomes unnecessary due to lack of need, it can be reestablished as available housing in the community.

Additionally, tribally operated AFHs can be eligible for 100% Federal Medical Assistance Percentage (FMAP) reimbursement. FMAP is a reimbursement rate that the federal government uses to match state Medicaid rates. Typically, this rate varies from state to state; however, Medicaid-eligible IHS or tribal providers can receive 100% FMAP, rather than the state's reimbursement rate. This means tribal provision of certain services, like HCBS, is reimbursed at 100% by the federal government and poses no cost to states.[1] This is an incentive for states to assist tribes with the establishment of tribally managed facilities to care for their elders, like AFHs (CMS, 2013b; Artiga & Damico, 2016). Tribes interested in

[1] https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/100-percent-fmap-educate-your-state.html

providing care in an AFH should look closely at this opportunity and communicate their needs to states to benefit from it.

Training

State regulations outline caregiver training requirements. Many states have (or can refer interested communities to) agencies or organizations that provide this training. Given the opportunity for 100% FMAP reimbursement, however, tribes might consider working with their state to establish a state-approved, culturally appropriate training course that could be offered by local organizations or agencies, such as a local tribal college. AFH staff recruitment and training could also take place in the community, further guaranteeing the provision of culturally appropriate LTSS (Zylstra, personal communication, March 14, 2016).

Next Steps

Based on findings from the literature and interviews with currently operating programs, several recommendations are available for tribes interested in implementing an AFH in their community:

- Designate a tribal champion—a person or organization—to lead the development and implementation process from start to finish.
- Review state AFH regulations and negotiate for any needed culturally sensitive training and care.
- Develop a work group that includes valued stakeholders, such as elected officials, tribal clinic directors, tribal elders, Title VI director, and a tribal social service director.
- Establish a partnership with the state licensing agency and/or the state Medicaid agency to engage their support as stakeholders, to begin early discussions, and to take initial steps to make the AFH eligible for 100% FMAP reimbursement.
- Secure tribal council support and sustained buy-in from tribal officials.
- If required, review the state's staff training curriculum and establish any additional requirements to ensure staff have the necessary knowledge and skills to provide culturally appropriate care.
- Seek licensure to operate an AFH or obtain a licensure equivalence by either meeting all of the licensure requirements or securing any necessary waivers.
- Research the process for and work to obtain Medicaid approval for an AFH through your state.
- Develop an AFH layout that fits the needs of the community's elders (Zylstra, personal communication, March 14, 2016).

Establishing programs and services in tribal communities that offer the same care as long-term care facilities (board and care, transportation, activities, and social engagement) benefits elders by allowing them to remain in their homes near family and in their communities. AFH programs and services are often cost-effective options for tribes and states looking to provide LTSS for tribal elders and vulnerable adults at home. AFHs stand as a possible option for these communities: home-based, cost-effective, and flexible enough to be adapted to address the particular needs and unique

cultural values of the communities in which they are based. These characteristics highlight the AFH model as a viable solution for tribes seeking to provide individualized, long-term care that allows cherished elders and family members to remain in the communities they call home.

At a Glance: Adult Family Homes at Work

Department of Veterans Affairs Medical Foster Home Program

The Department of Veterans Affairs (VA) established the Medical Foster Home (MFH) Program in 1999 to provide veterans with an alternative form of care that responded to preferences for home-based care options. There are over 100 VA facilities operating 677 MFHs, housing almost 1,000 veterans throughout the country. Thirty percent of the MFHs are state licensed, while 70% are homes that meet federal requirements. Each veteran receives 24-hour care in a home-like environment.

"It's a wonderful partnership between the VA and the community."

– Cindy Bahora, Idaho VA MFH Program Coordinator

Partnerships

VA's MFH Program:

- State Adult Family Home (AFH) program manager
- State licensing and certification agency
- Local adult family homes,
- Local MFH coordinator, and
- Veterans

VA's Home Based Primary Care (HBPC) Program Team:

- Physicians,
- Social workers,
- Psychologists,
- Dieticians,
- Rehabilitation therapists,
- Pharmacists, and
- Nursing staff (Levy et al., 2015)

Establishing a home

1. A local MFH coordinator establishes a network of AFHs that meet inspection and federal regulations to house veterans.
2. The veteran will work with the HBPC team and the MFH coordinator assess the veteran's need.
3. The veteran will visit homes that match the assessed care level to meet the caregivers.
4. The HBPC program can provide training to the caregiver.
5. The HBPC program will provide certain services based on the veteran's care plan.
6. The MFH coordinator will visit regularly with the veteran.

Funding

When comparing costs between an MFH and a facility, the MFH is much lower and provides individualized care (Levy et al., 2015).

- Veterans pay for room and board.
- Veterans use VA pensions or benefits, social security, Medicaid, or private insurance.

- The HBPC program covers and coordinates the medical care.

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