MODELS OF CARE
Family Care, Family Care Partnership, PACE

For more than 35 years, Community Care, Inc. has been a non-profit leader providing innovative, integrated, and cost-effective member-centered long-term care and fully integrated health care to Wisconsin’s frail elders and adults with physical and intellectual disabilities. Community Care is enabling thousands of members to achieve their best possible outcomes while living as independently as possible.

Our legacy is a commitment to quality and compassionate care, innovative program design, and responsible stewardship.

- Coordinated, member-centered care to 10,000 members.
- Comprehensive long-term care through Family Care and full integrated care through Family Care Partnership and Program of All-Inclusive Care for the Elderly, commonly known as the PACE program.
- A respected leader in innovative program design, offering the largest menu of long term care membership options in Wisconsin.
- The only PACE Program in Wisconsin.
- A trusted steward of resources.
- Currently serving 14 Wisconsin Counties from 20 sites.
All Community Care programs are funded through a Medicaid and/or Medicare capitated at-risk funding model. A potential participant in one of the Community Care programs requires that the individual meet the functional and financial eligibility criteria. Potential members are referred to Community Care through the local county Aging and Disability Resource Centers.
The Community Care programs provide comprehensive care management services to help members live as independently as possible. Each program uses a member-centered approach to planning and providing for the participant’s needs. This approach focuses on active listening to the member and his/her family, identifying personal outcomes, and assessing the social, functional and health needs of the member.

**Family Care** The Family Care program focuses on the long-term care services seniors and adults with disabilities need to live independently. Each Family Care member is assigned a dedicated Care Team that makes sure he or she receives the proper care and support to reach personal goals. Family Care provides needed home health, personal care, therapy, and other long-term care services that members need to remain independent and connected to their communities. The Care Team plays an active role in coordinating health services; however, since primary medical care is not a service offered under Family Care, members remain responsible for their own medical services, which are available through their Medicaid benefits.

**Family Care Partnership** The Partnership program provides a full range of long-term, primary, acute, and preventive care coordinated by the care team. Upon joining the program, each member selects a doctor from our large network of community-based primary physicians and is assigned a dedicated Care Team to help coordinate all of their health care needs. The Care Management Team works with the member and family to develop a plan for health, social and support services designed to achieve the member’s goals and assure needs are met.

**PACE** The PACE program is a nationally recognized model of care that provides a comprehensive primary, acute, preventive and long-term care. The care is coordinated and delivered through the interdisciplinary teams, and include a Community Care PACE primary care physician. The team works together to ensure each member’s social, personal, and medical care needs are met.
Following is a summary of the eligibility criteria, coverage, and description of the core Care Management team.

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<tr>
<th>Program*</th>
<th>Eligibility*</th>
<th>Services</th>
<th>Health Care Coverage</th>
<th>Core Care Team</th>
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<tbody>
<tr>
<td><strong>Family Care (FC)</strong>&lt;br&gt;86% of Membership</td>
<td>Frail elder (Age 65 and over) and Adults with disabilities (age 18 and over). Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Sheboygan, Washington, Waukesha, Walworth, Waupaca, Winnebago, Fond du Lac, and Manitowoc County residents.</td>
<td>Community-based long-term care services and care management. Examples of these services may include necessary in-home personal care, medical equipment, assisted living, transportation, and assistance with employment.</td>
<td>The Care Team is responsible for assisting in coordination of all aspects of a member’s health care needs, while acute and primary care is covered through Medicaid or Medicare.</td>
<td>The Member, a Registered Nurse and Care Manager comprise the Care Team.</td>
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<td><strong>PACE (Program of All-Inclusive Care for the Elderly)</strong>&lt;br&gt;7% of Membership</td>
<td>Age 55 and older, nursing home eligible as determined by the Wisconsin Adult Long-term Care Functional Screen (including dual eligible Medicare/Medicaid), and Milwaukee or Waukesha County Residents.</td>
<td>All-inclusive health, social and supportive long-term care services.</td>
<td>Complete integrated health care, including primary, acute.</td>
<td>The Member is the center of the Care Team. The interdisciplinary care team includes a Primary Care Physician, Nurse Practitioner, Registered Nurses, Pharmacist, Therapists, Personal Care Aides, and Social Workers. Plans, delivers, and oversees all care and services based out of adult day service centers.</td>
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<td>FC Partnership 7% of Membership</td>
<td>Frail Elders (age 55 and over) and Adults with disabilities (age 18 and over) who are nursing home eligible as determined by the Wisconsin Adult Long-term Care Functional Screen (including dual eligible Medicare/ Medicaid), Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Sheboygan, Washington, Waukesha, Walworth, or Waupaca County residents.</td>
<td>All-inclusive health, social and supportive long-term care services.</td>
<td>Complete integrated health care, including primary and acute.</td>
<td>The Interdisciplinary care team consists of the Nurse Practitioner, Social Service Coordinator/Care Manager, and a Registered Nurse Care Manager, with the member at the center of the team. Communication with the member’s community based physician is critical to continuity of care. Input from other disciplines such as pharmacy, therapy services, and dieticians is incorporated in the plan of care as the need arises.</td>
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*2015 Eligibility and Service areas, subject to change.
PROVIDER RESPONSIBILITIES

As a provider of care or services to Community Care beneficiaries, collaboration with the interdisciplinary care team is critical to developing a care plan which truly meets each member’s individual needs. As appropriate, PACE providers will be expected to participate in interdisciplinary care team meetings when requested to do so. Ongoing contact with our Nurse Practitioners, Care Managers, or RNs regarding assessment, care and services is an expectation of all contracted providers to ensure continuity of care. Care plans are updated at minimum semi-annually or with any change in condition.

For a listing of all “Provider Communication Requirements,” go to www.communitycareinc.org/for-providers/

Decisions on Allocation of Resources (RAD) All the Community Care health plans provide for the long term care needs of its beneficiaries. The interdisciplinary team takes great care in evaluating the needs of the members enrolled in Community Care programs. Prior to approving allocation of services and resources, the team carefully considers the resources available to the member as well as his/her goals of care. Community Care is responsible for supporting personal outcomes, but also must consider cost when planning care and choosing providers to meet each eligible member’s needs. The team will use a process called the Resource Allocation Decision (RAD) method. The RAD method is a step-by-step process the Team and member will use to find the most effective and efficient ways to meet the needs and support the member goals. The RAD process includes a series of questions that will help explore what is needed and the options that are available to support those needs. This may include how friends, family or other community and volunteer organizations may be available to help. The member is always included in this discussion.

All long-term care services must be approved BEFORE the eligible member receives them. Community Care is not required to pay for services received without prior approval. If you feel a service that is not already approved may be needed for our member, please make contact with the member’s assigned Care Manager or RN.

Community Care Inc.  Community Care Health Plan Inc.  Community Care HUD Housing Inc.
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