Money Follows the Person Rebalancing Demonstration

Closed Cases Report For 2014

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Introduction

As part of Connecticut's rebalancing efforts, the Money Follows the Person (MFP) Demonstration transitions residents in institutional facilities to the community. By 2018, Connecticut (CT) seeks to transition 5,200 people from qualified institutions to approved community settings. To achieve this goal, it is important to enable the transition of most individuals who express a desire to return to the community. in the early years of the demonstration, CT experienced a relatively high number of cases closed compared to cases transitioned. Therefore, in 2012 an analysis of case closures was undertaken to identify practices, service needs, and other areas in which improvements may assist the state in reducing case closures and increasing transitions. This is the fourth report produced from the analysis of closed cases. For the previous reports which analyzed closures January through June 2012 and July through December 2012, as well as a report for the full 2013 year please visit: University of Connecticut Center on Aging

In order to comprehensively cover the closed cases data, this report is divided into three sections. Section I is an overall picture showing the current status, as well as number and percent of transitioned and closed cases for *referrals made during 2014*. Section II shows a comparison of *cases closed during each of the six years* of the MFP program (2009-2014), and Section III provides specifics on *all cases closed during 2014*, regardless of the year in which the case was referred. In addition, Section III provides a detailed account of the specific reasons cases closed in 2014 in order to inform practice and allow program managers to make programmatic changes that decrease the number of preventable closures.

There are currently 14 reasons a case can be closed:

1. Participant not aware of referral and does not wish to participate
2. Participant would not cooperate with care planning process
3. Participant changed their mind and would like to remain in the facility
4. COP/Guardian refused participation
5. Participant moved out of state
6. Exceeds mental health needs
7. Exceeds physical health needs
8. Transitioned to community before informed consent signed
9. Reinstitutionalized for 90 days or more
10. Other
11. Nursing home closed and moved to another facility (excluded from analysis)
12. Died (excluded from analysis)
13. Non-demo: Transition services complete (excluded from analysis)
14. Completed 365 days of participation (excluded from analysis)

Methods

Numerical data for cases closed, cases transitioned and new referrals were obtained through Microsoft Access queries of MFP program data stored in the My Community Choices web-based tracking system.

For the purposes of this analysis, cases closed under the last four closure codes (11-14 above) were excluded because programmatic changes would not affect their occurrence: nursing home closed and moved to another facility, died, non-demo: transition services complete, and completed 365 days of participation. Also excluded were any additional referrals from nursing home closures regardless of the case closure reason.

Section I: Status of Referrals made between January and December 2014

A total of 1879 referrals were received during 2014. Excluding referrals that are currently closed due to the following reasons: died (148), completed 365 days of participation (11) and non-demo: transition services complete (2), the number of total referrals from 2014 is 1718. As of April 6, 2015, the current status of these referrals is distributed as follows:

Table 1: Current Status (as of 4/6/15) for 2014 referrals compared to those from 2013

Current Status	2014 Cases	*2014 %*	2013 Cases	2013 %
Closed (w/out transitioning)	**460**	***27***	**348**	***31***
Recommend Closure Approved (w/out transitioning)	**82**	***5***	**12**	***1***
Recommend Closure Initiated (w/out transitioning)	**20**	***1***	**10**	***1***
Transitioned (total)	**406**	***24***	**336**	***30***
- Open cases	384	*22*		
- Closed	9*	*1*		
- Closure recommended	12	*1*		
- Closure initiated	1	*0*		
In Progress (total)	**750**	***44***	**403**	***36***
- Assigned to Field	164	*10*	34	*3*
- Informed Consent Signed	163	*10*	205	*18*
- Care Plan Approved	395	*23*	137	*12*
- Transition Plan Submitted	17	*1*	23	*2*
- Transition Plan Approved	11	*1*	4	*0*
Total	**1718**		**1109**	

* These 9 closed and transitioned cases are included in the total closed cases in this report for a total of 469 cases closed

Of the 1718 referrals made in 2014, 27% (469) are now closed and another 115 (7%) are in the closure process (closure recommended, initiated, or approved). Twenty-two percent (384) are referrals that transitioned and are still open; the remaining 44% (750) are still active in the transition process. As of April 6, 2015, 24% (406) of referrals from 2014 had transitioned.

Cases referred during 2014 that transitioned (406) or closed (469) by April 6, 2015 were distributed by region, by Home and Community-Based Services (HCBS) package, and by target population as noted in Tables 2, 3 and 4. Closures are classified by reason closed in Table 5.

Regional variations in percentage of referrals transitioned were relatively low, ranging from 22% in the Southwest to 25% in the North Central region. Regional differences in the percentage of referrals closed were more notable. The South Central region closed 20% of its referrals, while the Southwest region closed 32% of referrals.

Table 2: Transitions and closures of referrals from 1/1/2014 to 12/31/2014 by region

Region	Referrals	Transitioned #	Transitioned % (of refs. in each region)	% of total transitions	Closed #	Closed % (of refs. in each region)	% of total closures (n=469)
Eastern	194	44	23	11	58	30	12
North Central	638	157	25	39	186	29	40
Northwest	257	60	23	15	75	29	16
South Central	410	97	24	24	81	20	17
Southwest	219	48	22	12	69	32	15
Total	1718	406			469		

Over three-quarters of referrals transitioned under one of three HCBS packages: the Physical Disability State Plan (PDSP), one of the CT Home Care Program for the Elderly (CHCPE) waivers/plans, or the Personal Care Assistance (PCA) waiver. Another 7 percent transitioned under the WISE Mental Health waiver (MH-WISE). By contrast, closed cases came primarily from those accepted to the CHCPE (48%); the PCA waiver (21%), and the WISE waiver (20%). Sixteen percent of closed referrals did not have an assigned HCBS package.

Table 3: Transitions and closures of referrals from 2014 by HCBS package

HCBS Package	Transitioned	%	Closed	%
ABI	8	*2*	9	*2*
CHCPE	2	*0.5*	132	*33*
CHCPE-AFL	3	*1*	1	*0.3*
CHCPE-AL	5	*1*	1	*0.3*
CHCPE-L1	1	*0.3*	0	*0*
CHCPE-PCA-AB	62	*15*	12	*3*
CHCPE-PCA-LI	66	*16*	28	*7*
CHCPE-PCA-SD	8	*2*	3	*0.8*
CHCPE-S	65	*16*	14	*4*
DDS	1	*0.3*	6	*2*
DDS-C	21	*5*	1	*0.3*
DDS-IFS	10	*2*	0	*0*
KB	1	*0.3*	0	*0*
MH-WISE	27	*7*	80	*20*
MHSP	1	*0.3*	2	*0.5*
OTHER	1	*0.3*	2	*0.5*
PCA	53	*13*	84	*21*
PDSP	71	*17*	20	*5*
Total	406		395*	

* There were an additional 74 closed cases that were missing the HCBS package

The greatest number of transitions (50%) and closures (64%) were older adults (Table 4). A higher percentage of referrals in the mental health target population were closed (16%) versus transitioned (8%). Both the developmental and physical disability target populations had a higher percentage of transitions than closures.

Table 4: Transitions and closures of referrals from 2014 by target population

Target Population	Transitioned	%	Closed	%
Developmental Disability	36	*9*	6	*2*
Elderly	202	*50*	207	*64*
Mental Health	31	*8*	53	*16*
Physical Disability	137	*34*	60	*18*
Total	406		326*	

* There were an additional 143 closed cases that were missing target population

Table 5: Closures of referrals from 2014 by reason compared to 2013

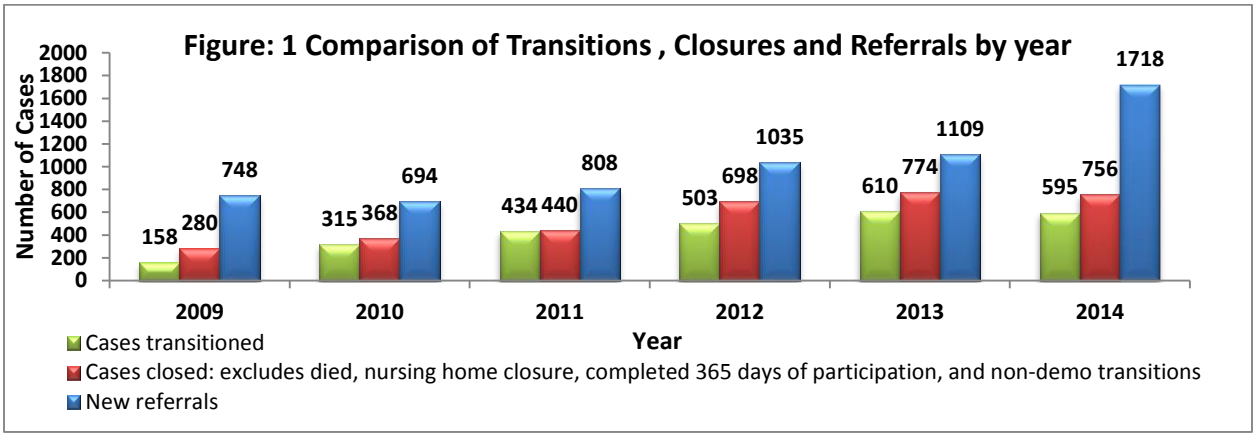
Closure Reason	Cases	%	2013 cases	2013 %
Transitioned to community before informed consent signed	182	*39*	41	*12*
Participant changed their mind and would like to remain in the facility	91	*19*	114	*33*
COP/Guardian refused participation	86	*18*	71	*20*
Exceeds physical health needs	30	*7*	23	*7*
Participant would not cooperate with care planning process	24	*5*	37	*11*
Other	21	*5*	8	*2*
Exceeds mental health needs	14	*3*	14	*4*
Participant not aware of referral & does not wish to participate	11	*2*	15	*4*
Reinstitutionalized for 90 days or more	5	*1*	19	*5*
Participant moved out of state	5	*1*	6	*2*
Total	469		348	

As seen in Table 5, compared to 2013, a much greater percentage of closed referrals in 2014 transitioned before informed consent was signed (39% vs. 12% in 2013). This is consistent with the mass referral of the backlog of applications – some of these people already left before the case was assigned to the field. Meanwhile, the relative percentage of referrals closed because the participant changed their mind fell in 2014 (19% vs. 33% in 2013), and the percentage of referrals which closed because the participant would not cooperate with care planning also

decreased (5% vs. 11% in 2013). The new process added engagement services specifically to reduce these types of closures. It is possible these services contributed to these decreases – if so, this trend will likely continue in 2015.

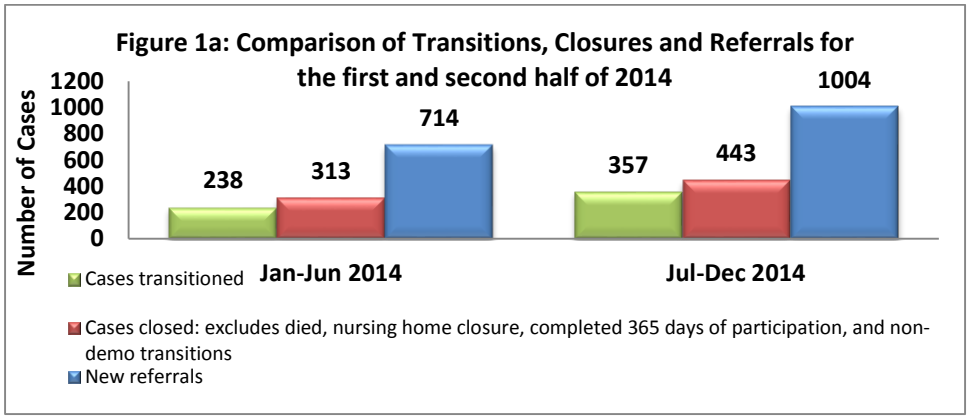
Section II: Comparison of Closed Cases by Year, 2009-2014

During 2014 MFP experienced 1718 referrals, 595 transitions and 756 closures (referrals and closures exclude those that closed due to the 4 excluded reasons). Compared to 2013 there was a 55% increase in new referrals, a 3% decrease in cases transitioned, and a 2% decrease in cases closed. The increase in referrals reflects a new transition process begun in March of 2014, including the creation of a new Specialized Care Manager position and reorganization of field staff into regional teams. This allowed Central Office to refer to the field many of the consumers who had applied to MFP but were waiting to be assigned to the field due to lack of assessment staff.

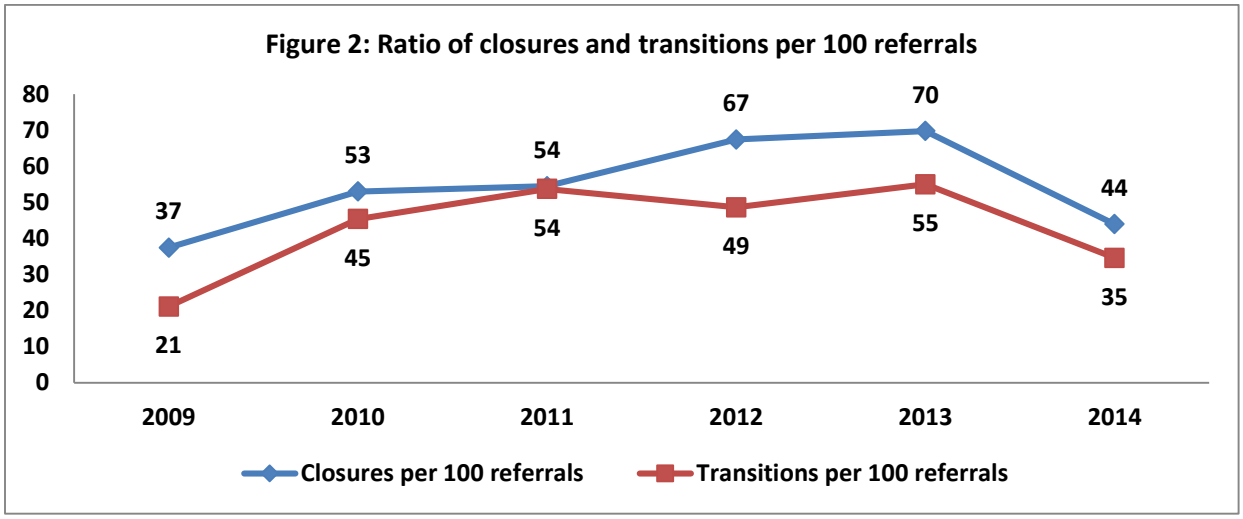


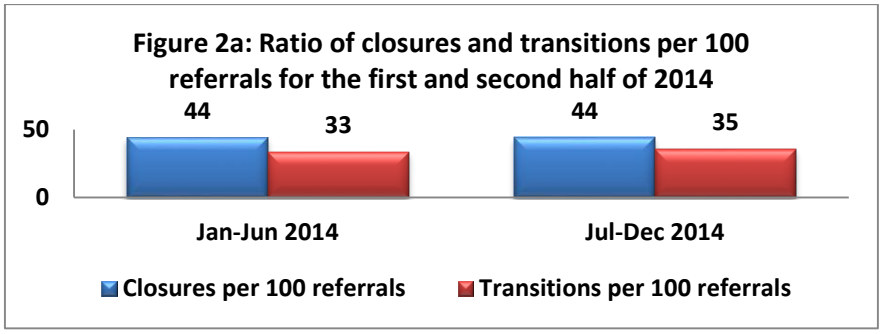
Whenever there is a large number of referrals, the number of transitions often drops or slows down as TCs and HCs in particular are working with these new referrals to get them transitioned. Often this trend is followed in the next time period by an increase in transitions. The new process was designed to decrease the number of closed cases – the 2% decrease in closed cases may be a good sign, though the 3% decrease in transitions should be monitored to determine if it is a temporary result of the new process or a worrisome trend.

The change to the new transition process is evident in Figure 1a as well. With the new staff and process fully underway, transitions increased in the second half of the year. Central Office assigned more waitlisted referrals to the field later in 2014 as more teams were created. Unfortunately, due to this waitlist and delay from application to assignment, a greater than usual proportion of these waitlisted referrals were immediately closed for reasons such as the consumer had already left the facility, had died, or his/her health or other circumstances had changed.



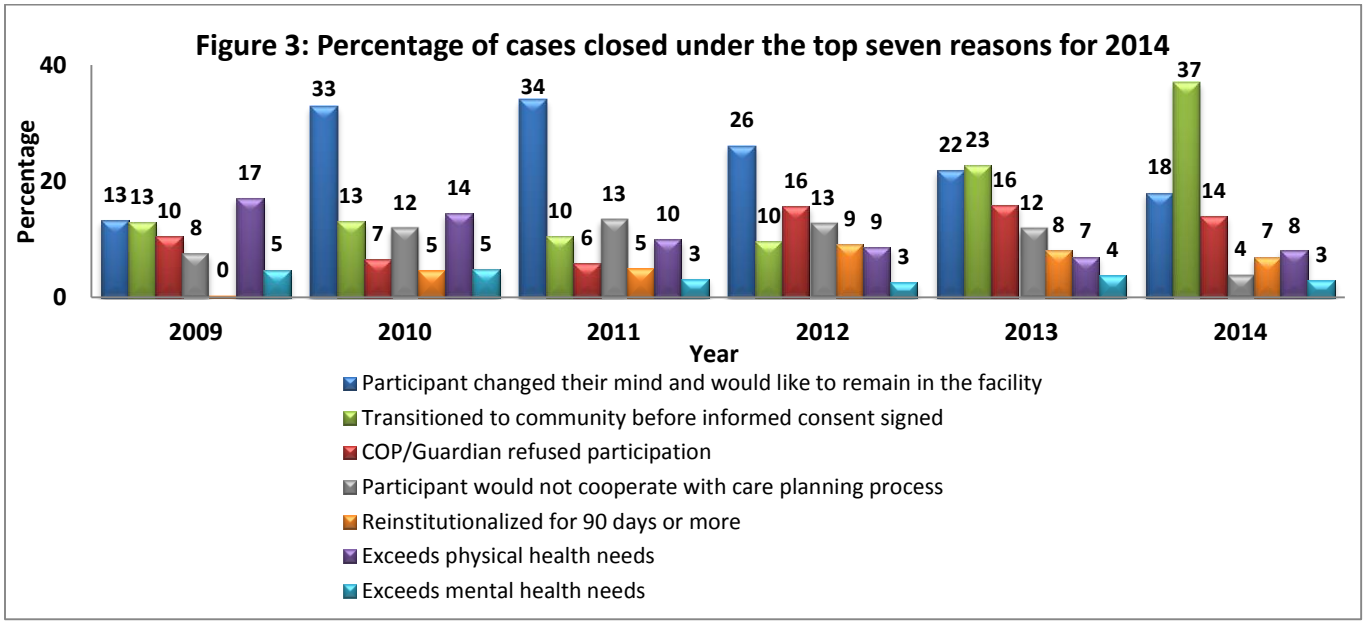
Continuing the trend of prior years, in 2014 the CT MFP program closed more cases than it transitioned (see Figures 2 and 2a), although both closures and transitions per 100 referrals were down substantially from 2013. One factor for 2014 was certainly the mass referral of hundreds of waitlisted MFP applicants, many of which were quickly closed as explained above. Closure and transitions per 100 referrals for the first half of the year were virtually identical to the second half.





Considering all cases that closed during 2014 regardless of referral year (n=756, without the 4 excluded closure reasons), the most frequent reason cases closed was "Transitioned to community before informed consent signed" (see Figure 3). This reason accounted for 37%

(n=279) of closures during 2014, a 14% increase from 2013. This large increase is likely due to the mass referral of waitlisted applicants, who made different arrangements while awaiting referral. The second highest reason for closing a case during 2014 was "Participant changed their mind and would like to remain in the facility," accounting for 18% (n=132) of closures, a four percent decrease from 2013. The percentage of cases closed upon request of the COP or guardian also decreased slightly from 2013 (14% vs. 16%). The percentage of cases closed in 2014 because of high physical health needs (8%), re-institutionalization of 90 days or more (7%), or high mental health needs (3%) showed very little change from 2013. On the other hand, the percentage of cases closed because the participant would not cooperate with care planning process dropped notably from the year before – only 4% of cases closed because of this in 2014, compared with 12% in 2013. Engagement services and motivational interviewing training were added specifically to address readiness for change on the part of consumers and other involved individuals; it is possible these new services supported the decrease in the percentage of cases closed due to participant changing his/her mind, COP refusing participation, and participant noncooperation with care planning. The full effect of these services on closed cases will not be seen until 2015.



Section III: Analysis of Cases Closed Between January and December 2014

A total of 1519 cases closed during 2014 regardless of the year they were referred to MFP. Cases that closed due to the following reasons were excluded: died (282), completed 365 days of participation (425), and non-demo transition services complete (56); the number of closed cases for further analysis in 2014 is 756. The remainder of this report focuses on these 756 closures (see Table 6). Table 6 shows basic characteristics of cases that closed under each reason. More detailed analysis was completed by reviewing the progress notes and the "My Community Choices" web information for a random sample of cases for each closure reason.

Table 6: Characteristics of consumers whose cases closed in 2014

Closure Reasons	Closures N (%)	Female N (%)	Male N (%)	Age Range	Age Avg	% 65 or older	Days from referral to closure Range	Days from referral to closure Avg
Transitioned to community before informed consent signed	279 (37)	132 (35)	147 (39)	17-97	60	33	0-257	n/a*
Participant changed their mind and would like to remain in the facility	132 (17)	66 (18)	66 (17)	26-103	72	71	17-1924	267
COP/Guardian refused participation	105 (14)	47 (13)	58 (15)	19-95	72	66	7-1096	221
Other	58 (8)	22 (6)	35 (9)	25-90	61	39	1-944	176
Exceeds physical health needs	57 (8)	39 (10)	18 (5)	44-82	61	26	21-1776	304
Reinstitutionalized for 90 days or more	51 (7)	34 (9)	17 (5)	31-95	67	51	n/a	n/a
Participant would not cooperate with care planning process	29 (4)	11 (3)	18 (5)	40-98	67	59	9-540	183
Exceeds mental health needs	23 (3)	12 (3)	11 (3)	27-68	54	13	34-1090	246
Participant not aware of referral and does not wish to participate	11 (2)	7 (2)	4 (1)	47-88	69	55	13-138	70
Participant moved out of state	11 (2)	6 (2)	5 (1)	37-85	61	55	21-958	402

Note: Percent totals may not equal 100 due to rounding

*The average days to closure cannot be accurately calculated for this closure reason due to missing referral dates. Those cases missing referral dates (n=110, 39%) were never assigned to the field, often because they already transitioned to the community between applying to MFP and when their cases were ultimately going to be assigned to the field.

A detailed analysis of the most frequent closure reason "transitioned to community before informed consent signed" (n=279, 37%) was limited due to the lack of specific information. Nearly 40% of these cases (n=110) were never assigned to the field because they left the institution before assignment, leaving few notes on their activity. However, these consumers were more likely to be younger compared to consumers in other categories, with an average age of 60 and only a third age 65 or older (see Table 6). The mass assignment of the backlog of applications to the field meant that, in some cases, once the Specialized Care Manager received the referral and contacted the facility, he/she found out that the consumer had already transitioned without the assistance of MFP. These cases were then closed immediately. It

should also be noted that the nearly 40% of cases that were never assigned, or "referred" to the field as mentioned above, do not have referral dates.

Cases that closed due to the reasons "participant changed their mind and decided to stay in the facility" and "COP/Guardian refused participation" had the highest average age of 72 years, with two-thirds or more age 65 or older. Although down by 4% from 2013, cases that closed because the participant changed their mind and wanted to stay in the facility still represented 17% (n=132) of all closures in 2014 and represented the second most common reason. Similar to previous years, an in-depth analysis of these cases showed the main reasons the participants changed their mind were: acclimation to the facility – feeling "comfortable" living there, the perception by consumers that their physical or mental health needs were significant and would be better met at a facility, wanting to go back to an old residence that was no longer a possibility, consumers being happy with the socialization at the facility, and the consumer's concern that living in the community would lead to an increase in isolation. The average length of time from referral to closure was 267 days, with a range of 17-1,924 days; 1,924 was the longest number of days for any of the reasons cases closed this year. The average age of consumers closed for this reason in 2014 was 2 years younger than in 2013.

A few quotes from several case notes where consumers changed their mind and decided to stay in the facility highlight these reasons:

- *"Consumer stated that she felt safe and happy there and wants to stay."*
- *"Consumer feels that the proposed plan would not be sufficient to meet his needs. Consumer reports that he is concerned over periods of time with no assistance. All of his family is in West Virginia. There is reportedly nobody in the area that could serve as backup or even assist him in the community for short periods of time."*
- *"Client refused assessment stating she would like to remain in the SNF [skilled nursing facility], her house is being sold and she does not wish to move into an apartment. The client also stated her son is moving to Maine and future plans could include relocating to Maine with her son."*
- *"SCM [specialized care manager] met with consumer at SNF with spouse present. He reports that he was interested in MFP when his wife was still in the community. She recently moved to the same SNF and they share a room. He is not interested in leaving SNF or in MFP at this time."*

Cases closed because the "COP/Guardian refused participation" accounted for 14% (n=105) of overall closures in 2014, down 2% from 2013. Similar to previous years, the main reasons COPs and guardians cited for their decision were a decline in consumer health from the time of the referral and the belief that the consumer needs 24-hour care to ensure their safety in the community. Two other common reasons were that the legal representative did not want to either be part of the back-up plan or to manage the consumer's personal care assistants (PCAs). Many of these consumers have mental health and memory issues and are unable to manage other health issues, such as diabetes, on their own. Some illustrative case notes include:

- *"Conversation with sister [name]/COP. COP feels that safest place for client at this time is SNF. Due to client's complex health conditions - he requires 24/7 supervision and RN 4XD to administer two different insulin. Client is not able to manage his diabetes. Family is unwilling to get involved. Client has HX [history] of substance abuse and sister is convinced that he will go back to drinking as soon as he [leaves] SNF. Client has an end stage of renal failure. At this point - COP decided that client will remain in SNF."*

- *"Daughter/POA [power of attorney] for Mrs. [name] stated that since referral to MFP there have been multiple hospitalizations and a decision for long term placement has been made."*

- *"Durable POA reports that she would rather have him remain in the SNF for structure and socialization. Does not feel that he would benefit from living in the community with a live-in more than he would at SNF."*

- *"Wife is client's POA- she stated that "[name] can't go home. I was not aware of this referral... I am not interested in MFP, [name] is happy where he is. I can't take care of him." Wife is not interested in MFP program, she does not want her spouse to return to the community."*

- *"Conservator would like to close referral as consumer has not been medically stable going from psych ward to medical ward since Feb 2014."*

- *"Spoke with his brother who is his conservator and he is very opposed to any move to a setting without 24 hour support. He felt he would be unsafe due to his history of falls and need for constant supervision and support with ADLs."*

Exceeding physical health needs accounted for 8% of closures (n=57), a one percent increase from 2013. Some examples of this reason include:

- *"At this time the client would require nursing visits three times per day for insulin injections as well as finger sticks for sliding scale coverage. The cost of nursing services as well as other services client will require to ensure health and safety, RA and CSP, will greatly exceed the cost cap."*

- *"SCM called and spoke to consumer in order to inform her that her case will be closed as the waiver does not currently meet her medical needs (2 person Hoyer transfer). SCM explained if she can continue to work on being able to assist with transfers then she can re-apply to the program."*

- *"Received proposed care plan, client with a diagnosis of dementia, unable to self-direct PCAs, family does not wish to participate with the MFP program. Client's POC [plan of care] exceeds the cost cap."*

Reasons for closing a case due to exceeding mental health needs accounted for 3% of overall closures (n=23). Similar to findings from 2012 and 2013, these consumers mainly had a diagnosis of anxiety, depression, or bipolar disorder. The main health issues continue to be

mental health, uncontrolled diabetes, the need for dialysis multiple times a week, and dementia.

- *"Client has dementia - cannot sign for himself, no COP/COE - family has not called back or made contact, client will be 64 in April and can be assessed by the Elder Waiver."*
- *"Client was d/c'd [discharged] from Chelsea Place to the IOL [Institute of Living] in Hartford. Client requires a higher level of care. The IOL is trying to get client admitted to CVH [CT Valley Hospital]."*

Reinstitutionalization for 90 days or more accounted for 7% of overall closures (n=51), down by 1% from 2013. A variety of reasons contributed to participants needing to be re-admitted to an institution including: a long-term hospital stay or multiple hospitalizations; complications arising from a fall; various health reasons such as diabetes, mental health, stroke, or wound care; and substance use problems.

Finally, cases closed because the participant would not cooperate with the care planning process represented 4% of cases closed in 2014, a 8% decrease from 2013. Establishing Medicaid eligibility for consumers who were over income or assets played a role in just under one-third of these cases.

- *"Client over income limit; refuses Pooled Trust in order to become financially eligible."*
- *"Client moved out of facility prior to any plans, not living at reported address, whereabouts unknown."*

Another noteworthy point was that 112 of the cases closed in 2014 were closed more than one year after referral. These represented 19% of closed cases (excluding cases without referral dates and those closed for the 4 excluded closure reasons). Reasons these cases closed varied. The reason with the lowest average amount of time from referral to closure was "participant not aware of referral and does not wish to participate" at 70 days, and the highest was "participant moved out of state" with an average of 402 days. Interestingly, the participants who changed their mind and decided to remain in the facility due to feeling happy and/or comfortable there were not necessarily those that had a longer average time between referral and closure. It was often the participants with declining health that had changed their mind and wanted to remain in the facility that had the longer average time from referral to closure.

Transition Challenges

Compared to previous reports, the distribution and order of transition challenges for cases closed in 2014 differed somewhat (see Table 7). As in 2013, physical health was still the biggest challenge, identified as a challenge for 18% consumers, similar to the 17% in 2013. In 2013, it was followed by challenges related to mental health (14%), waiver/HCBS package (13%), consumer engagement (13%), housing (10%), and services and supports (10%). In 2014, field staff identified housing as the second largest challenge, representing 15% of cases. This was followed by services and supports (12%), mental health (11%), waiver/HCBS package (10%), and consumer engagement (9%).

Table 7: Transition challenges by category for cases closed in 2014 and 2013

Transition Challenges	2014 %	2013 %
Physical health	18	17
Housing	15	10
Services and Supports	12	10
Mental health	11	14
Waiver/HCBS package	10	13
Consumer engagement	9	13
Financial	8	5
MFP Central Office	5	4
Involved others	4	6
Legal	4	4
Facility	2	2
Other	2	2

Over half (53%) of those with physical health challenges had the sub-challenge 'Current, new, or undisclosed physical health problem or illness.' For consumers with housing challenges, almost half (49%) did not have affordable, accessible community housing. Consumers with services and supports challenges most often faced challenges related to lack of PCA, home health, or other paid support staff (38%) and lack of transportation (22%). Consumers with mental health challenges most often faced challenges related to current, new, or undisclosed mental health problem or illness (30%) and dementia or cognitive issues (29%). Specific housing concerns identified were that the consumer wanted to go back to the housing situation they were in before they went into the facility, but then found that it was not possible, for reasons such as necessary modifications were not possible or the house was sold.

Multiple factors likely account for this re-ordering of the top six challenges. Year 2014 saw the implementation of a new transition process, with the development of a new field position and creation of regional teams. This allowed for the assignment of many waitlisted MFP applications, some of which were quickly closed as the person was no longer at the facility. The addition of new field staff meant that the TCs and HCs could have more open cases.

Conclusion

Many of the 2014 findings were similar to the 2012 and 2013 closed cases reports. As in 2013, there continues to be a growing awareness of MFP among consumers, legal representatives, and other stakeholders. Some consumers had previous referrals or knew someone who had transitioned with MFP. Consumers' characteristics were similar to 2012/13 consumers; for example, consumers whose cases closed due to changing their mind and deciding to stay in the facility had the highest average age (72), while consumers closed for exceeding mental health needs had the lowest age average (54). Similar to last year, some consumers reported feeling happy and/or comfortable at the facility and did not want to move to the community due to fear of isolation. This observation offers an area that could be addressed in multiple ways, such as proactively connecting consumers, along with family and friends, to community and recreational programs prior to transition, or providing transportation to social activities and

programs. This might also be a good opportunity for MFP to collaborate with community resources such as community centers, to facilitate the consumer connecting with, or even better, participating in community programs prior to transition.

Closures due to prolonged reinstitutionalization have been decreasing slowly since 2012; effective prevention of reinstitutionalization is still a key factor. Identifying and mitigating the risk of falls is critical to preventing reinstitutionalizations that frequently follow falls. There continues to be a core 11% of cases closed because the consumer's mental or physical health needs exceed the allowable cost. MFP would likely benefit from continuing to look for creative strategies to address these issues, such as nurse delegation of medication administration, and greater use of services which can be shared, such as Adult Family Living services.

As described earlier, 2014 saw a large increase in older referrals sent to the field, which corresponded with an increase in the percentage of cases closed because they had already left the facility without the assistance of MFP. Although lower than in previous years, 36% of closures in 2014 closed due to either the participant changing his/her mind, COP/legal representative refusing participation, or the participant not cooperating with care planning. Engagement services and motivational interviewing training were added specifically to address readiness for change on the part of consumers and other involved individuals. There may be some benefit gained by proactively addressing COP's or guardian's concerns around their family member's transition to the community, particularly for those consumers whose cases closed due to COP/guardian request or participant changing his/her mind. Perhaps this could be addressed through training provided to legal representatives or family members on specific issues such as community services (i.e. transportation, activities/recreation), caregiver supports, or PCA employer training.