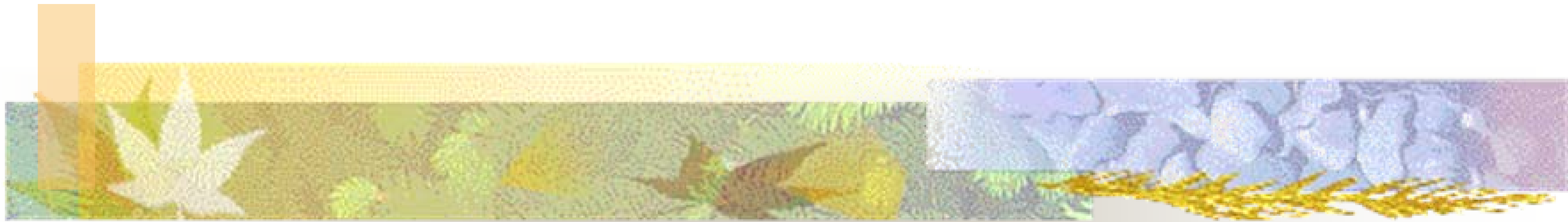
Transition Planning and Risk Assessments



Presented by:

Suzy Quinlan and Suzanne Huffman

- SPD Mission Statement
- Case Manager’s Role in Risk Management
- Transition Planning
- Options and Requirements for assessing risks
- Risk Assessment Tools & Identifying Risks
- Implementing interventions to mitigate risks
- What to do when risks cannot be mitigated
- Risk section of the CAPS Client Details
- STEPS - Benefits of using this program
- Natural Supports

SPD Mission Statement

- The SPD mission is to make it possible to become independent, healthy and safe
- SPD contributes to the DHS mission by helping seniors and people with disabilities of all ages achieve well-being through opportunities for community living, employment, family support and services that promote independence, choice and dignity

Case Manager's Role in Risk Mgmt

- Identify individuals at risk
- Identify what risk factors the individual has
- Work with individual to eliminate or minimize the risks
- Monitor & continue to offer options over time, to assist the individual in evaluating risks and developing a plan

Transition Planning – What is it?

- **Transitioning happens when:**
  - Clients move from one care setting to another
  - Changes occur in the service plan
  - Services are closed
  - Services are reduced
  - Client accepts less than the assessed in-home hours
  - The client chooses not to accept services

Transition Planning – Why is it necessary?

- To successfully move from one service setting to another
- Identify available resources:
  - For individuals that need to transition into a new living situation when services are closed
  - When SPD or a AAA can no longer offer the same level of services
  - For individuals that are institutionalized, such as nursing facilities – this is a CMS requirement
- CMS waiver requirement to identify risks & to minimize or eliminate risks
- For individuals not receiving services, assist in eliminating or reducing risks, such as for Risk Intervention services

- **Requirement:**
  - Assessing and identifying risks
  - Work with individual to eliminate or reduce risks
  - Documenting risks in the Client Details RISK section of CAPS
- **Options of tools to use for assessing Risks:**
  - Risk Assessment Tools discussed in this Netlink
    - located on the CM Website
  - Risk Assessment Tool that your SPD/AAA local office recommends
  - Assess and mitigate RISKS by directly entering the info into the Client Details Risks section of CAPS

Risk Assessment Tools

Case Management Website

- **Generic Risk Assessment Tool**
  - Risk Assessment Tool Guidelines
  - Additional Requirements and Guidelines
- **NWSDS Client Risk Assessment tool**
  - NWSDS Service Review, Client Monitoring & Risk Assessment Policy

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RISK ASSESSMENT

Branch # ___________

Individual's Name: ______________________________ **Prime #** ___________

SCORES	U = Unknown	0 = No Risk	1 = Low Risk	2 = Moderate Risk	3 = High Risk

I. CLIENT FACTORS	U	0	1	2	3	**Comments:**
1. Physical Functioning (ADLS / Diagnoses)						
2. Mental/Emotional Functioning						
3. Cognitive Functioning						
4. Behavioral Issues						
5. Income/Financial Issues						
II. ENVIRONMENTAL FACTORS						**Comments:**
6. Safety/Cleanliness of Residence/Facility						
7. Service Plan Meet's Client's Physical/Medical Needs						
8. In-Home/Facility Service Plan Meets Client's Mental/Emotional/Behavioral Needs						
III. SUPPORT FACTORS						**Comments:**
9. Adequacy/Availability of Informal Supports (Family/Friends/Other)						
10. Access to Needed Care/Services (Medical, MH, Transportation, Telephone, Emergency Response System, etc)						

RISK LEVEL – if the individual has one or more risk factors (use the highest risk factor listed above)

0 – 1.0 No or Low Risk
2.0 Moderate Risk
3.0 High Risk

Completed By: ______________________________ **Date:** ___________

The Assessment Tool was developed by the Northwest Senior & Disability Service (NWSDS) in Oregon. *Document was last modified by Seniors and People with Disability (SPD) CO.*

Instructions for using the Risk Assessment Tool:

The Risk Assessment tool may be used to:

- Document an individual's observed risk factors
- Assist in planning to address and reduce risk
- Assist in determining frequency of case manager contact with the individual
- Track individuals who have lost services or have been placed in other services
- Track individuals who may lose services due to loss of funding

The Risk Assessment can also be completed more than once for an individual, to document and quantify changes in the individual's risk level.

The Risk Assessment is divided into three categories:

- Client Factors
- Environmental Factors
- Support Factors

Each category has from three to five risk categories to be assessed. Assess each factor, using your best professional judgment to determine the level of risk, and check the appropriate box. Refer to the attached Risk Factor Descriptions for an analysis of the risk factors. Note: the descriptions provided are characterizations for each level of risk; they are examples of possible circumstances, and are not intended to be all-inclusive.

The assigned values in the document are as follows:

- U = Unknown, unable to determine
- 0 = No risk
- 1 = Low risk
- 2 = Moderate risk
- 3 = High risk

Use the comments section adjacent to each factor to briefly record details regarding the selected risk level.

I. CLIENT FACTORS	NO RISK - 0 -	LOW RISK - 1-	MODERATE RISK - 2 -	HIGH RISK - 3 -
1. PHYSICAL FUNCTIONING	Ambulatory. No physical challenges. Capable of all ADLs and IADL's.	Ambulatory. Minimal physical challenges, e.g., hearing loss. Capable of most ADLs and IADL's, e.g., eating, dressing, personal hygiene and using telephone.	Reduced capacity. Moderate physical challenges e.g., some loss of hand or arm movement. Requires cane, walker or hands on assistance to ambulate. Capable of few ADLs, e.g., eating and dressing.	Severe incapacitation. Bedridden. Chronic disease. Blind. Severe loss of hand or arm movement. Loss of speech. Rapid deterioration of functional abilities. Incapable of most or all ADLs. Completely dependent on others.
2. MENTAL and EMOTIONAL FUNCTIONING	No apparent mental or emotional challenges.	Minimal mental or emotional challenges. Willing to accept needed assistance.	Exhibits some abnormal behavior, e.g., expresses paranoid ideation, but is able to maintain ADLs. Decompensated mental illness. Resists needed services. History of depression.	Developmentally disabled. Suicidal ideation. Depression. Hostile, violent, acting out. Express paranoid ideation. Withdrawn. Displays inappropriate laughter or crying. Refuses needed services.
3. COGNITIVE FUNCTIONING	No apparent cognitive impairment. No confusion.	Mild forgetfulness, but remembers to pay rent and utilities. Anxiety over forgetfulness. Willing to accept assistance.	Periodic confusion. Impaired reasoning capacity. Inappropriate answers to some questions. Sometimes forgets to pay rent or utilities. Resists offers of guidance, e.g., won't use public transport or give up driving.	Confusion. Disoriented to person, place or time. Forgets to pay rent and utilities. Incapable of preparing meals and forgets to eat. Denies confusion; refuses needed services.
4. BEHAVIORAL ISSUES	No problem behaviors or indication of substance abuse.	Minor problem behaviors, e.g., history of substance abuse but no current abuse. Willing to accept assistance.	Moderate problem behaviors, e.g., intermittent meds, non-compliance, or occasional failure to make Doctor's appts. Occasional substance abuse.	Severe problem behaviors that place the client at high risk, e.g., wandering, current substance abuse/ addiction, or life-threatening medical non-compliance.
5. INCOME / FINANCIAL ISSUES	More than adequate income to provide for necessities. Financially independent.	Adequate income for necessities only. No safety net. Financial dependence upon others for emergency expenses, etc.	Major financial dependence on others. Barely able to provide for life's necessities. Sometimes must choose between necessities, e.g., medicine or food.	Totally dependent upon others financially. Or, adequate income but unable or unwilling to provide for life's necessities.

1. Physical Functioning
2. Mental & Emotional Functioning
3. Cognitive Functioning
4. Behavioral Issues
5. Income/Financial Issues

1. Physical Functioning

- **No Risk**
  - Capable of all ADLs and IADLs

- **Low Risk**
  - Minimal physical challenges, such as hearing loss
  - Capable of completing most ADL and IADLs
  - Need for minimal ADL and IADL assistance

Physical Functioning – continued….

- **Moderate Risk**
  - Reduced physical abilities, such as:
    - Partial loss of hand or some arm movement limitations
    - Requires use of assistive devices, such as a walker or cane
    - Hands on assistance to ambulate
  - Capable of a few ADLs only

Physical Functioning – continued….

- **High Risk**
  - Severe physical capability
  - Bedridden
  - Chronic diseases
  - Severe physical challenges
  - Incapable of most or all ADLs and IADLs
  - Totally dependent on others

2. Mental & Emotional Functioning

- **No Risk**
  - No apparent mental or emotional limitations observed or reported
- **Low Risk**
  - Minimal mental or emotional challenges
  - Willing & cooperative to accept needed assistance

Mental & Emotional Functioning

– continued….

- **Moderate Risk**
  - Exhibits some abnormal behaviors, such as paranoid ideation, but is able maintain ADLs
  - Decompensating Mental & Emotional functioning
  - Resistive to needed services
  - History of unstable depression

Mental & Emotional Functioning

– continued….

- **High Risk**
  - Developmental disability
  - Suicidal ideation
  - Depression
  - Hostile
  - Violent
  - Acting out
  - Expresses paranoid ideation
  - Withdrawn
  - Inappropriate laughter or crying
  - Refuses needed services

3. Cognitive Functioning

- **No Risk**
  - No apparent Cognitive impairment
  - No observed or reported cognitive issues, such as confusion & memory issues
- **Low Risk**
  - Mild forgetfulness, but remembers to pay rent & utilities
  - Anxiety over forgetfulness
  - Willing to accept services

Cognitive Functioning – continued….

- **Moderate Risk**
  - Periodic confusion
  - Impaired reasoning
  - Inappropriate answers to some questions
  - Sometimes forgets to pay rent & utilities
  - Resists offers of guidance, won’t use public transportation or give up driving

Cognitive Functioning – continued….

- **High Risk**
  - Considerable or severe confusion
  - Disoriented to person, place or time
  - Forgets to pay rent & utilities
  - Incapable of preparing meals & forgets to eat
  - Deny confusion
  - Refuses needed services

- **No Risk**
  - No apparent problems with behaviors
  - No indication or known substance or alcohol abuse problems
- **Low Risk**
  - Minor problem behaviors
  - History of substance or alcohol abuse, but no current abuse
  - Willing to accept assistance

Behavioral Issues – continued….

- **Moderate Risk**
  - Moderate problem behaviors, such as
    - Taking medications intermittently or choosing not to follow medical recommendations
    - Failure to make or keep doctor’s appointment
    - Occasional substance or alcohol abuse problems

Behavioral Issues – continued….

- **High Risk**
  - Severe problem behaviors that place individual at risk, such as
    - Wandering
    - Current substance or alcohol abuse/addiction
    - Making Life-threatening medical choices

5. Income/Financial Issues

- **No Risk**
  - Adequate income to provide for necessities
  - Financially independent
- **Low Risk**
  - Adequate income for necessities only
  - Financial dependence upon others for emergency expenses, etc.

Income/Financial Issues – continued….

- **Moderate Risk**
  - Major financial dependence on others
  - Barely able to provide for life's necessities
  - Sometimes must choose between necessities, such as medicine or food
  - History of financial exploitation

Income/Financial Issues – continued….

- **High Risk**
  - Totally dependent upon others financially

    or

  - Has adequate income but unable or unwilling to provide for life's necessities

II. Environment Factors	NO RISK - 0 -	LOW RISK - 1 -	MODERATE RISK - 2 -	HIGH RISK - 3 -
6. SAFETY/ CLEANLINESS/ OF RESIDENCE/ FACILITY	Structure appears sound and sanitary. No major repairs needed/no exposed trash or odor. No threat of eviction.	Sound structure but old, e.g., needs painting. Utilities operative. Sanitary, but undesirable housekeeping standards, e.g., odor from trash, thick dust, etc. Threat of eviction.	Deteriorating structure. Safety problems posing a degree of risk. Unsanitary conditions. Some animal droppings or pest infestation or undisposed garbage. Some interruption of utilities, or access issues (e.g. steep stairs) or threat of eviction.	Unsound or condemned structure. Serious health risks, e.g., severe pest/rodent infestation. Human and or pet waste present. Utilities terminated or inoperative. Residence poses problems that place client at immediate high risk, e.g., no heat or water, caved-in ceiling. Eviction in progress. Or homeless.
7. IN-HOME/ FACILITY SERVICE PLAN MEETS CLIENT'S PHYSICAL/ MEDICAL NEEDS	Care/service plan meets all of client's medical and physical needs, and client accepts care/services	Some minor or occasional issues with care/service provision, but client's basic medical/physical needs are met. No threat of eviction.	Care/service plan fails to meet some of client's medical or physical needs, or client refuses some needed care, but risk to client's health is not serious or imminent. Threat of eviction.	Client at serious or imminent risk due to inadequacy of in-home or facility care/services to meet client's critical needs. Or client refuses critical physical or medical care. Eviction in progress/medical
8. IN-HOME/ FACILITY CARE PLAN MEETING CLIENT'S MENTAL/ EMOTIONAL/ BEHAVIORAL NEEDS	Care/service plan meets all of client's mental/emotional/behavioral needs, and client accepts care/services	Some minor or occasional issues with care/service provision, but client's basic mental/emotional/ behavioral needs are met. No threat of eviction	Care/service plan fails to meet some of client's mental, emotional or behavioral needs, or client refuses some needed care, but risk to client's health is not serious or imminent. Threat of eviction	Client's at serious or imminent risk due to inadequacy of in-home or facility care/services to meet client's critical emotional/behavioral needs. Client refuses critical care/services. Eviction in progress/behavioral.

II. Environmental Factors

6. Safety/Cleanliness of Residence/Facility
7. Service plan meets individual's Physical & Medical need
8. In-Home Service Plan meets individual's Mental/ Emotional/ Behavioral needs

6. Safety/Cleanliness of Residence/ Fac..

- **No Risk**
  - Structure appears sound and sanitary
  - No major repairs needed
  - No exposed trash or odor
  - No threat of eviction
- **Low Risk**
  - Sound structure but old & needs some repairs, such as painting
  - Utilities operative
  - Sanitary, but undesirable housekeeping standards, such as odor from trash, thick dust, etc…
  - Threat of eviction

Safety/Cleanliness of Residence/Fac…

- continued….

- **Moderate Risk**
  - Deteriorating structure
  - Safety problems posing a degree of risk
  - Unsanitary conditions
  - Animal droppings or pest infestation or undisposed garbage
  - Interruption of utilities
  - Access issues, such as steep stairs
  - Threat of eviction

Safety/Cleanliness of Residence/Fac…

- continued….

- **High Risk**
  - Unsound or condemned structure
  - Serious health risks, such as severe pest/rodent infestation
  - Human and/or pet waste present
  - Utilities terminated or inoperative
  - Residence poses problems that place the individual at immediate high risk, such as no heat or water, caved-in ceiling
  - Eviction in progress
  - Homeless

7. Service plan meets individual's Physical & Medical needs

- **No Risk**
  - Service plan meets all of client's medical and physical needs *and*
  - Client accepts care/services
- **Low Risk**
  - Some minor or occasional issues with care/service provisions, but client's basic medical/physical needs are met
  - No threat of eviction based on a lack of service assistance

Service plan meets individual's Physical & Medical need – continued….

- **Moderate Risk**
  - Service plan fails to meet some medical or physical needs ***or***
  - Refuses some needed care, but risk to individual's health is not serious or imminent
  - Threat of eviction

Service plan meets individual's Physical & Medical need – continued….

- **High Risk**
  - Client at serious or imminent risk due to inadequacy of in-home or facility services meeting critical needs

    or
  - Client refuses critical physical or medical care
  - Eviction in progress due to lack of physical or medical care

8. Care Plan Meets Mental/Emotional/ Behavior Needs

- **No Risk**
  - Service plan meets all mental/ emotional/ behavioral needs *and*
  - Individual accepts services
- **Low Risk**
  - Some minor or occasional issues with service provisions, but individual's basic mental/ emotional/ behavioral needs are met
  - No threat of eviction

Care Plan Meets Mental/Emotional/ Behavior Needs – continued….

- **Moderate Risk**
  - Service plan fails to meet some mental, emotional or behavioral needs ***or***
  - Individual refuses some needed care, but risk to client's health is not serious or imminent
  - Threat of eviction

Care Plan Meets Mental/Emotional/ Behavior Needs – continued….

- **High Risk**
  - Individual is at serious or imminent risk, due to inadequacy of in-home or facility care/services because of critical emotional/ behavioral needs or problems
  - Client refuses critical services
  - Eviction in progress/behavioral.

III. SUPPORT FACTORS	NO RISK - 0 -	LOW RISK - 1 -	MODERATE RISK - 2 -	HIGH RISK - 3 -
9. ADEQUACY/ AVAILABILITY OF INFORMAL SUPPORTS	Family and/or friends are actively involved to assist, and client accepts assistance	Family and/or friends are concerned but provide only limited assistance.	Family and/or friends are unreliable. Provide little or no help. Express good intentions but rarely follow through.	Family and/or friends interfere with client's needs being met, or are abusive/neglectful. Family members are estranged, or client has no known family/friends, is isolated.
10. ACCESS TO NEEDED CARE/ SERVICES (Medical/Mental Health/ Transport/ Telephone/ Emergency Response System [EMS])	No formal services needed, or client has unimpeded access to all needed services.	No physician/MH care, but no apparent medical / mental health needs. Client generally willing to seek services. Transportation problematic but available.	Client has medical / mental health care needs but does not have/cannot access it. Transportation problematic. Limited access to phone or other method of summoning help. Client somewhat resistant to needed services.	Client has significant medical / mental health needs but receives no care, or refuses available care. Transportation unavailable or client refuses to use it. No phone or client is too confused to use it. No Emergency Response System (EMS) or client refuses to use it.

III. Support Factors

9. Adequacy/Availability of Informal Support
10. Access to Needed Care/Services, such as Medical, MH, Transportation, Telephone, Emergency Response System, etc…

9. Adequacy/Availability of Nat Support

- **No Risk**
  - Family, friends or other supports are actively involved to assist, and client accepts assistance
- **Low Risk**
  - Family, friends or other supports are concerned but provide only limited assistance

Adequacy/Availability of Nat. Support

– continued….

- **Moderate Risk**
  - Family, friends or other supports are:
    - Unreliable
    - Provide little or no help
    - Express good intentions but rarely follow through
    - Physically unable to provide assistance, although would like to be involved

Adequacy/Availability of Nat. Support

– continued….

- **High Risk**
  - Family, friends or other supports:
    - Interfere with individual’s needs being met
    - Are abusive/neglectful
    - Are estranged
    - Individual has no known family, friends or other supports

10. Access to needed Services

- **No Risk**
  - No formal services needed *or*
  - Has unimpeded access to all needed services

- **Low Risk**
  - No physician/MH care, but no apparent medical / mental health needs
  - Generally willing to seek services
  - Transportation problematic but available

Access to needed Services

– continued….

- **Moderate Risk**
  - Has medical / mental health needs but does not have or cannot access assistance for it
  - Transportation problematic
  - Limited access to phone or other methods of summoning help
  - Somewhat resistant to needed service

Access to needed Services

– continued….

- **High Risk**
  - Has significant medical / mental health needs but receives no care, or refuses available care
  - Transportation unavailable or client refuses to use it
  - No phone or is too confused to use it
  - No Emergency Response System (ERS) or refuses to use it

Implementing Risk Interventions

For the three areas of identified Risk Factors:

- Client Factors
- Environmental Factors
- Support Factors

Implementing Interventions based on the Risk Assessment Tool

- **Risk Assessment Tool Guidelines**
  - Use your professional judgment & common sense:
    - Frequency & type of contact
    - Reducing or Eliminating risk factors for Low, Moderate or High Risk Individuals
  - Tool is not a requirement
  - Guidelines for using the tool is not a requirement
  - **Risks section of Client Details is a requirement**

Case Manager’s Role in Risk Intervention

- Minimize or eliminate risk
  - Offer choices and options
  - Evaluate and Identify Natural Supports
  - Refer to community resources or programs available
    - Home Delivered Meals
    - Adult Day Services
    - Emergency Response System
    - Community Health Support services, previously called CRN
    - ADRC-Aging & Disability Resource Connection website
      - www.ADRCofOregon.org
- Monitor and continue to offer options over time

Aging & Disability Resource of Oregon

ARDC website has information:

- FAQ about ARDC
- Self-assessment of needs
- Learn about Community Services & Resources
- Get connected to Services
- Find Oregon's Licensed Facilities
- Local Assistance and Help
- Other Resources, such as CMS or other agency info

Risks that cannot be mitigated

- Continue periodic monitoring
- Continue to offer interventions and solutions to minimize the risk
- Discuss the risks with the individual
  - Document in CAPS Client Details – Risk section:
    - The individual's ability to understand & accept or decline any plan or intervention
    - Document which items the individual accepted & refused

Risks - Client Details Plan/Comments

- **Plan/Comments are used:**
  - There is a risk, but no appropriate selection
  - To document the Facility's Responsibility to reduce risk factors
  - Next slide has additional reasons

Risks - Client Details Plan/Comments … continued

- Identify risks needing clarification
- Identify how each risk is or is not going to be resolved
- Explain solutions offered to minimize the risk
- **After the risk has been discussed with the individual, document the individual's ability to understand and accept or decline any plan or intervention**
  - **Document which items the individual accepted and refused**
- Enter the name, address & phone number of person that is assisting with the risk and how this person will assist the individual
- Used for CAPS2 Emergency Concerns Report – next slide

CAPS2
Emergency Concerns Report

- **Risk section of CAPS Client Details**
- **Must select Power Outage, Natural Disaster/ Extreme Weather:**
  - Only 3 selections that carry over to the report
  - Only select if the individual needs prompt response
  - Develop contingency plan for in-home plans
  - CBC or nursing Facilities are responsible to develop contingency plans for emergencies
  - Document in the CAPS Risks Plan/Comments

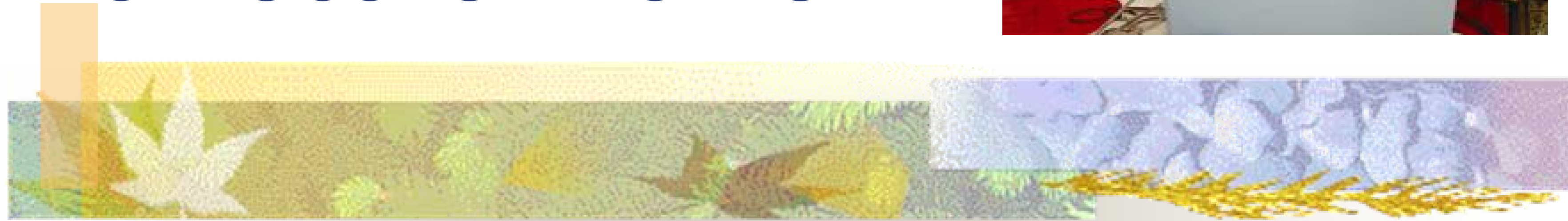
Addl Requirements & Guidelines

continued from previous slide

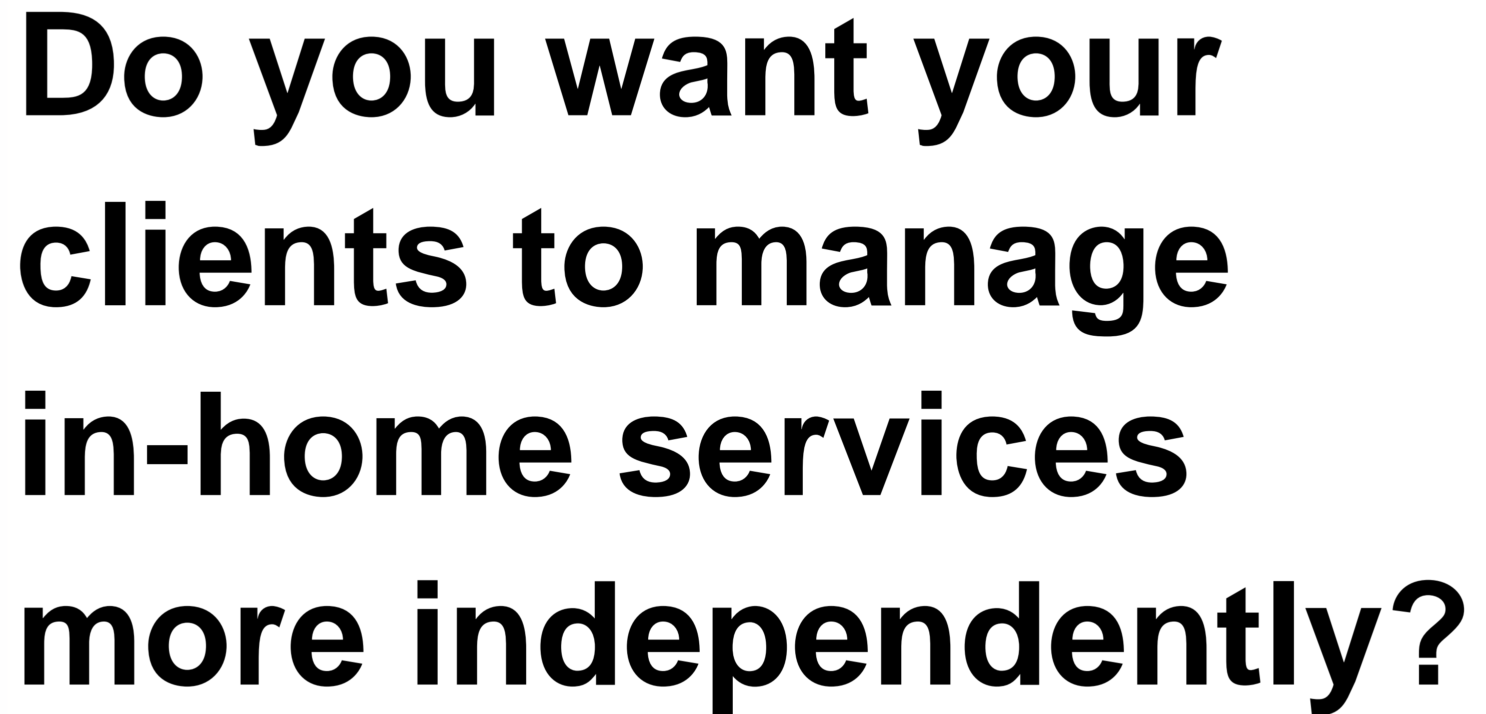
When should a reassessment be completed?

A CAPS reassessment is required minimally every twelve months. A reassessment must occur more often if the individual has a significant change of condition reported from the individual or another source that could alter the service plan. The service plan will be adjusted as needed.

STEPS to ***SUCCESS*** with your Homecare Worker



Presented by: Suzanne Huffman


Do you want your clients to manage in-home services more independently?

STEPS Benefits Case Managers…

- Clients better understand employer role and responsibilities
- Fewer calls about homecare worker (HCW) issues
- Decreased HCW turnover
- Follow-up and collaboration

STEPS Benefits Consumer-Employers…

- Learn and improve employer skills
- Gain confidence in ability to hire and supervise HCWs
- Feel ownership of process
- Assume control over *and* responsibility for quality of services and daily life
- Access CIL information and referral and other services

The guiding principle of STEPS:

Choice

\+ Responsibility

Empowerment

CONSUMER

CHOICE

- Hiring homecare worker
- Daily schedule
- Priorities
- Budgeting service hours
- How and when authorized services will be provided

RESPONSIBLITIES

- Client-Employed Provider Program Participation Agreement (SDS 0737)
- Communicating expectations
- Maintaining appropriate boundaries
- Planning for home safety and emergencies

How STEPS Promotes Success

- Reviewing rights and responsibilities
- Encouraging informed choices
- Providing written guides and forms, including job descriptions, employment agreements, and more…

What does the STEPS curriculum include?

- Understanding the Service Plan and Task List
- Creating job descriptions
- Locating employees
- Interviewing and completing reference checks
- Selecting the best Homecare Worker for the job
- Creating an Employment Agreement
- Training, supervising and communicating effectively with employees
- Ensuring that work is performed satisfactorily…

Curriculum, continued

- Maintaining employment records
- Scheduling and tracking authorized hours worked
- Approving paid leave and unexpected absences
- Recognizing, discussing and attempting to correct any employee performance deficiencies
- Discharging unsatisfactory workers
- Developing a backup plan for coverage of services
- Making the home a safe place for consumer-employers and employees

STEPS Tools For
Day-to-day
Management

Services and Tasks Worksheet

Services	Tasks (describe the routine you like?
1.	
Time – How long will it take?	
2.	
3.	

	Date	Task	Done
1			
2			
3			
4			
5			

Homecare Worker Daily Sign-In Sheet

Date	HCW Name	Time in	Time out	Daily Hours	Employee Initials	Employer Initials

What
case managers
say about
STEPS…

STEPS helps my clients:

- *understand their true role*
- *be better employers*
- *gain knowledge*
- *be more specific about how they want things done.*

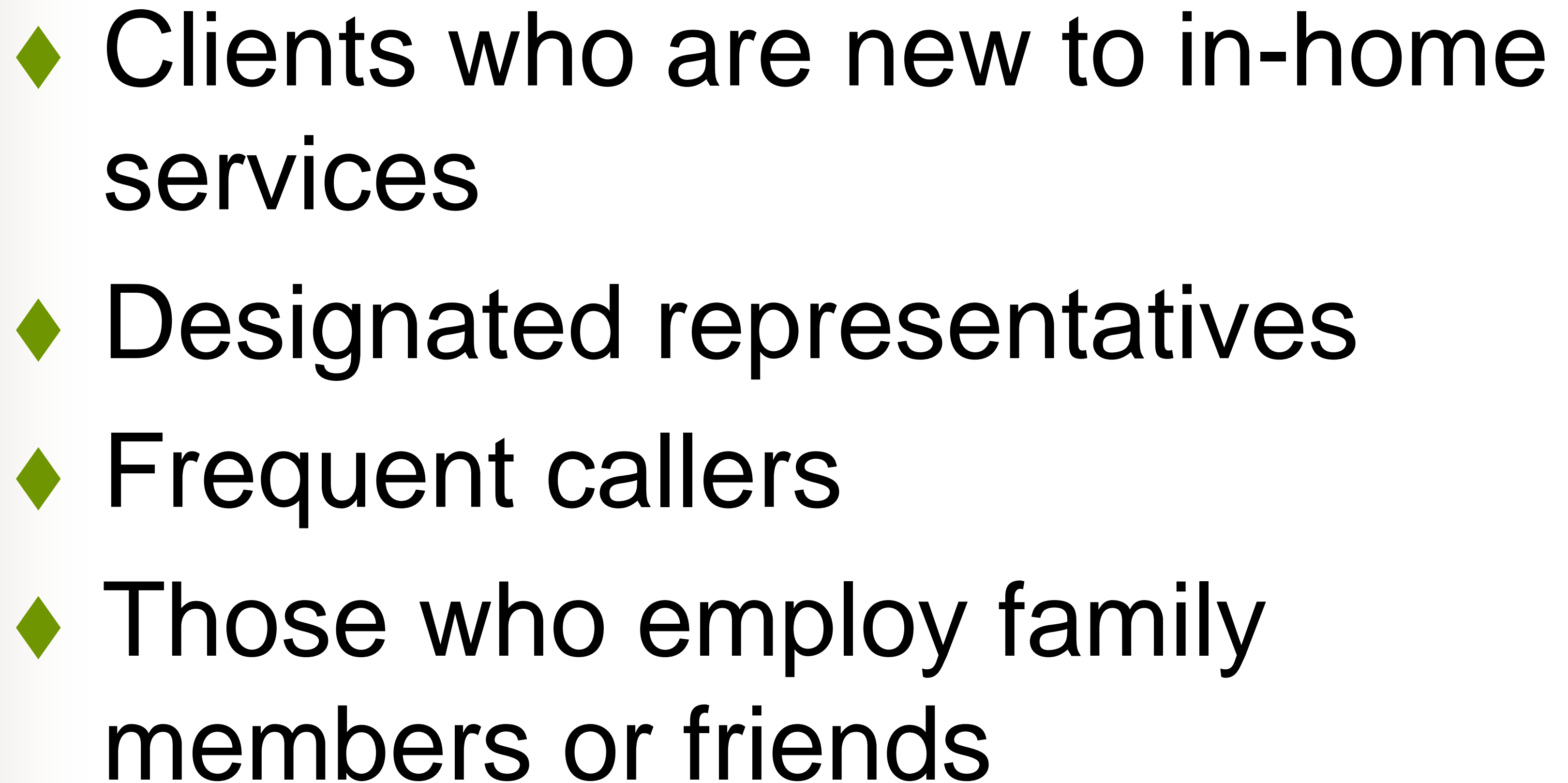
My clients have learned about:

- *their rights and responsibilities*
- *how to interact with the HCW*
- *how to communicate needs in a forthright and non-apologetic way*
- *how to direct their own services*
- *how to get started on their own safety plan.*

The program helps clients who:

- *habitually make questionable decisions about hiring/firing HCWs*
- *are taking direction from workers rather than the other way around.*

Who benefits most from STEPS?



- Clients who are new to in-home services
- Designated representatives
- Frequent callers
- Those who employ family members or friends

Refer clients when…

- the service plan changes
- there is frequent HCW turnover
- things are going well!

- Workshops
- One-to-one sessions
- Optional “Guide-on-the-Side” follow-up

Workshop Scheduling

- Provide contact information to Center for Independent Living
- The STEPS Coordinator will…
  - ✓ arrange one or more workshops
  - ✓ contact consumer-employers
  - ✓ follow up with you as needed

Workshop Mailing: Brochure and "Ticket"

FREE WORKSHOP ~ LUNCHEON
$25 GIFTCARD ~ HANDBOOK
ADDITIONAL SUPPORT IF NEEDED

Tuesday, March 29, 2011 ~ 11AM - 2PM

County Senior Center

Space is limited! Please register one week in advance by calling (503) 555-1212 or talking with Mary.

See brochure for gift card eligibility information. In-home consultations are available for those unable to attend.

STEPS *is presented by your area* **Center for Independent Living** *in partnership with your case manager's office.*

Individual Referrals

- Visit www.oregon.gov/DHS/STEPS
- Click STEPS locations at bottom of page, then:
  - Call Coordinator (numbers are in Contact list by county) OR
  - Download Referral Form to fax or email

STEPS to *SUCCESS* with Your Homecare Worker

Referral Form

Case Manager Information

Name:	
Branch:	
Phone Number:	
Fax Number:	
Email:	

Do you wish to receive a progress update? Yes ☐ No ☐

A STEPS Specialist will…

1. prepare a list of HCWs, if needed
2. meet with client and/or representative
3. stress employer responsibilities and how to use the task list
4. provide feedback to you on consumer-employer's progress
5. schedule follow-up appointments as needed

Take the first STEPS…

Contact your area Specialist to schedule a workshop or make an individual referral.

QUESTIONS ?

Natural Supports

Evaluating Natural Supports in new and long-standing cases:

- **Emphasis on good assessment of natural supports at the initial intake**
- Must evaluate natural supports on-going:
  - May not be any new natural supports
  - Natural support may no longer be available or sufficient
  - May reduce services based on new supports
  - May close services based on new supports

What are Natural Supports?

<u>OAR 411-015-0005(20) & 411-030-0020(30)</u>

- Informal, unpaid resources
- Relatives/Family
- Friends
- Neighbors
- Roommates
- Significant others
- Community resources or agencies
  - Senior Centers
  - Advocacy and Support Groups
  - Churches
  - Home Delivered or congregate meals
  - Emergency Response Systems
  - Veterans Services
  - Veterans Services

Case Manager Role in Natural Supports

1. Assess existing supports
2. Explore potential new informal supports
3. Identify community resources that could decrease the need for paid services
4. Not to replace or supplant natural supports

The Case Management Role

1. Assessing existing supports

- Establish natural supports at the initial service assessment (also for on-going assessments)
  - Difficult to reduce paid services once they have been previously authorized.
- Establish natural supports for on-going assmts
- Determine who is involved in the individual's support system?
- What kind of help do these supports provide?
- What are the community resources, if any, and do they currently meet some or all of the needs?

Case Management Role (continued)

2. Exploring potential new informal supports

- Are there support persons who might be willing to do extra tasks?
- Are there supports living with or near the client who might provide help?
- Is the client involved in any community organizations who might be able to provide some help?

Case Management Role (Continued)

3. Identifying community resources that could decrease need for paid services

- Senior Centers
- Advocacy and Support Groups
- Churches, synagogues
- Home-delivered or congregate meals
- Emergency Response Systems
- Veterans Services
- ADRC-Aging & Disability Resource Connection website (discussed in an earlier slide)

Case Management Role (continued)

4. Do Not replace or supplant natural supports

- Build a plan to supplement existing resources – for initial & on-going services
- Do NOT pay persons already providing unpaid care
- Do NOT remove unpaid support persons and replace them with paid providers

Pitfalls and Assumptions

- **Do Not assume Natural Supports are:**
  - **Available**
  - **Sufficient**
  - **Reliable *or***
  - **Able to meet the needs of the client**

Pitfalls and Assumptions

Pitfalls

- Family lives with client & help some
- Family lives with client & is unemployed
- Family is providing services now
- Roommates or others in the Household

Assumption

- They will meet all the needs
- They are available to meet all the needs
- They will continue to be available
- They will help out & can automatically be considered a natural support

** Look around and observe **

Natural supports may exist when:

- Medication placed in weekly pill box
- The apartment is clean and neat
- Laundry and clothes are folded and put away
- Mail is on the counter
- Family photos walls
- Neighbor asks why you are there
- Refrigerator has plenty of food and leftovers
- Cupboards are well stocked with food

Considerations when Assessing Natural Supports

- Who is in the individual's life?
- What are they doing for the individual now?
- What could they be doing, if asked?
- Is the support providing all the services unpaid?
- Is the support willing to provide some unpaid hours, if we pay for other hours?
- Are their concerns about the support person's skills to provide paid care?
- Evaluate what needs will likely be met anyway even if we don't pay for them.

Discussion Questions for Assessing Informal Supports

- What are you doing for your (relative, neighbor, friend) now?
- How long have you been providing that assistance?
- What kinds of things are you able to help your (relative, friend, neighbor) with?
- Is there any reason you would not be able to continue providing that assistance?
- Were you providing these services up until now? If so, what has changed?

What to ask when exploring potential new Informal Supports

- When you do your own shopping, can you pick up items for the client?
- What services can you continue to provide?
- Are you meeting your own housekeeping needs, and preparing your own meals? If so, can you also provide these services for the client since you live in the same home?
- Do you cook, eat, shop together?
- Can you pick up the client's prescriptions when you go to the pharmacy to pick up your own medications?

Payment Considerations

- Situations when some level of payment may be appropriate:
  - "My health is failing and I can't provide the care anymore."
  - "I can't afford to provide care for my relative anymore. I need to get a job to make ends meet."
  - "I am too burned out to keep providing the kind of help I am doing now."
  - "I prefer the natural support to provide for my personal care, instead of a complete stranger."
- May pay for hours for remaining unmet needs

Common statements focused on Payment rather than Service needs

- "If I don't get paid for providing care, then I am going to stop doing it."
- "I won't be able to make my house payment if I can't be paid as the clients provider."
- "My neighbor's niece is getting paid and all she does is my neighbor's laundry."
- "If you are going to pay someone else why can't you pay me?"
- "The client and I just got married. Can I continue to get paid?"

Common Statements which will lead you to ask more clarifying questions

- "I'd like to get paid for taking care of my relative."
- "I do everything for my relative."
- "Yes, my father lives with me but he doesn't help me at all. "
- "My roommate only takes care of his half of the house."
- "My daughter has her own family to take care of."

Factors in payment decisions:

- Consider the whole context of the situation
- No factor is an automatic reason to pay
- No factor is an automatic reason not to pay

Payment Factors to consider

- Extent of care needs
- Support availability
- Support distance: is support right next door or coming across town just to provide help?
- Client preferences
- Personal care and intimacy concerns
- Language and communication
- Cost effectiveness
- Adaptive equipment/community resources

RAFH and Natural Supports

- RAFH is an all or nothing payment
- Consider natural supports prior to setting up RAFH:
  - Is it cost effectiveness?
  - Does the current situation support the plan?
- Do NOT set up a RAFH when:
  - Relative provides for all services as a natural support
  - Relative doesn’t want to be paid for any needs, and meets all the needs of the client
- In-home plan with outside provider can be set up for unmet needs within the relative’s home as long as the relative is not paid for any services in the plans

Community Resources that may

Decrease need for service hours:

- Emergency Response Systems
- Home-Delivered Meals
- Assistive devices/service animals
- Lifespan Respite
- Family Caregiver Support
- Older Americans Act/OPI programs
- Commission for the Blind
- Other resources that may replace or reduce a need for a paid service

Why Evaluate Natural Supports?

OAR 411-015-0000 Purpose

- To serve the most functionally impaired
- To serve those with no or inadequate alternative service systems; and
- To manage limited resources through a priority system based on the individual's assessed need

OAR 411-030-0040 Eligibility Criteria

- Payments are **<u>not</u>** intended to:
  - *Replace the resources available from natural supports*
- Payments can be considered or authorized when resources are:
  - *Not available or*
  - *Not sufficient or*
  - *Cannot be developed to adequately meet the needs*
- Payment can **<u>not</u>** be authorized if service needs are fully met by a natural support
- Least costly means of providing care

In-Home Services Program

OAR 411-030-0070 Maximum Hours of Service

- Authorized hours are subject to availability of funds
- To reduce paid in-home service hours, CM must assess & utilize appropriate:
  - *Natural supports*
  - *Cost-effective assistive devices*
  - *Durable medical equipment*
  - *Housing accommodations*
  - *Alternative service resources*
- In-home services are paid:
  - *To supplement potential or existing resources*

In-Home Services Program

OAR 411-030-0050 Case Management

- To meet the identified assessed needs, the Service Plan must consider:
  - *In-home service options*
  - *Assistive devices*
  - *Architectural modifications, and*
  - *Other community-based care resources*

- SPD Case Management Tools
  http://www.dhs.state.or.us/spd/tools/cm/index.htm

- Assessment, Narration & CAPS Tools
  http://www.dhs.state.or.us/spd/tools/cm/capstools/index.htm

  - **New – Risk Assessment section with:**
    - Generic Risk Assessment Tool
    - Generic Risk Assessment Tool Guidelines
    - NWSDS Risk Assessment Tool
    - NWSDS Service Review, Client Monitoring & Risk Assessment Policy
  - **New - Assessing Natural Supports**

    http://www.dhs.state.or.us/spd/tools/cm/capstools/natural_supports.pdf

- ADRC-Aging & Disability Resource Connection
  www.ADRCofOregon.org

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