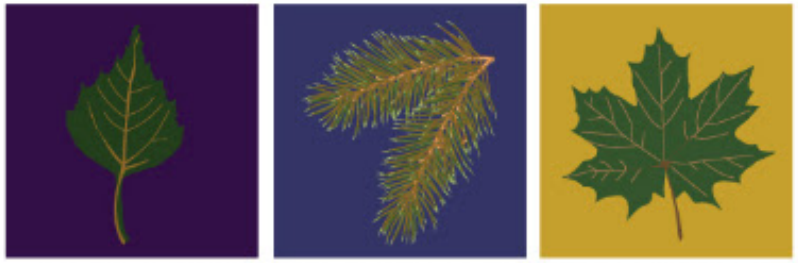


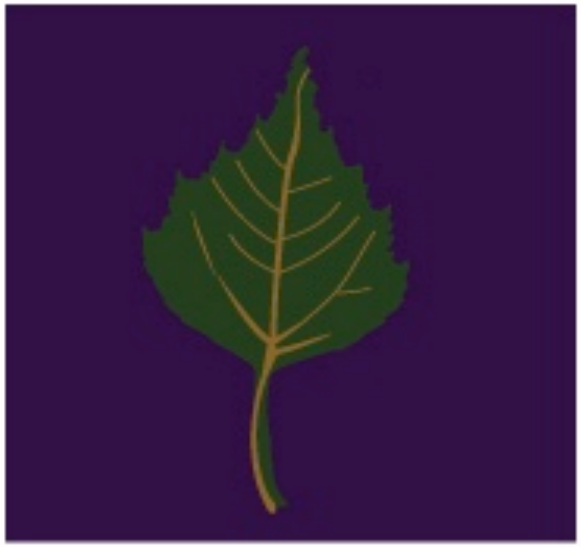
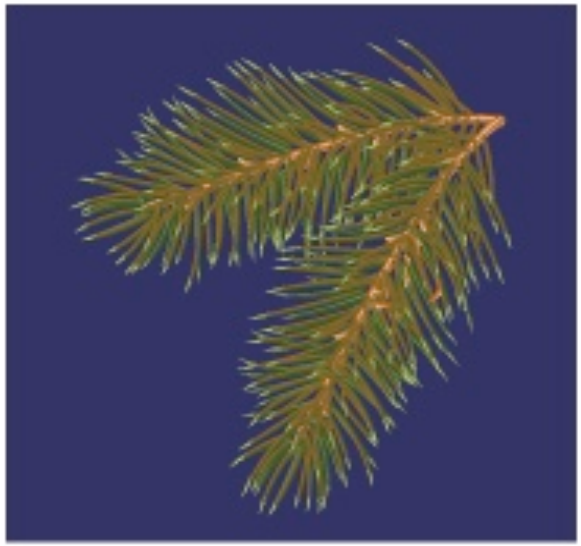
TRI-STATE LEARNING COLLABORATIVE ON AGING

Welcome to
Today's Webinar

The Power of Planning

Tri-State Learning Collaborative on Aging

Our mission: Increasing the collective impact of aging in place initiatives through shared learning in New Hampshire, Maine & Vermont


Thank you to our Funders!

THE BINGHAM PROGRAM

MEHAF MAINE HEALTH ACCESS FOUNDATION

ENDOWMENT *for* Health

JOHN T. GORMAN FOUNDATION

Maine Community Foundation

NEW HAMPSHIRE CHARITABLE FOUNDATION

THE Vermont Community Foundation

www.agefriendly.community

Webinar Housekeeping

Audio issues?
Try calling in using your telephone!

To be **unmuted** click here & virtually raise your hand

Send **questions** to us by typing them in here.

TRI-STATE LEARNING COLLABORATIVE ON AGING

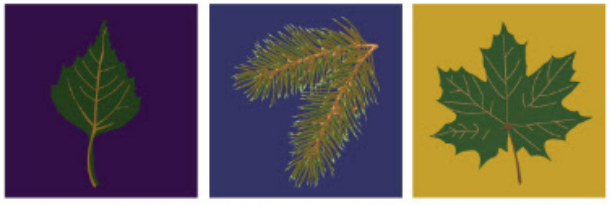
Announcements

TRI-STATE LEARNING COLLABORATIVE ON AGING

Save the Date:

June 20 | Fireside Inn | Lebanon

Embracing the Options: Supporting End-of-Life Care in Your Community



Today's Webinar

The Power of Planning

TRI-STATE LEARNING COLLABORATIVE ON AGING

Introducing Today's Speakers

Kate Crary
Project Director
UNH Center on Aging
and Community Living

Laura Davie
Co-Director
UNH Center on Aging and
Community Living

Nate Miller, LMSW
Community Services Manage
SeniorsPlus
Lewiston, Maine

CENTER FOR AGING AND
COMMUNITY LIVING

THE COMMUNITY LIVING GUIDE:

DEVELOPMENT, SUPPORT, AND LESSONS LEARNED

PRESENTED BY: KATE CRARY AND LAURA DAVIE

PCP is Really Culture Change

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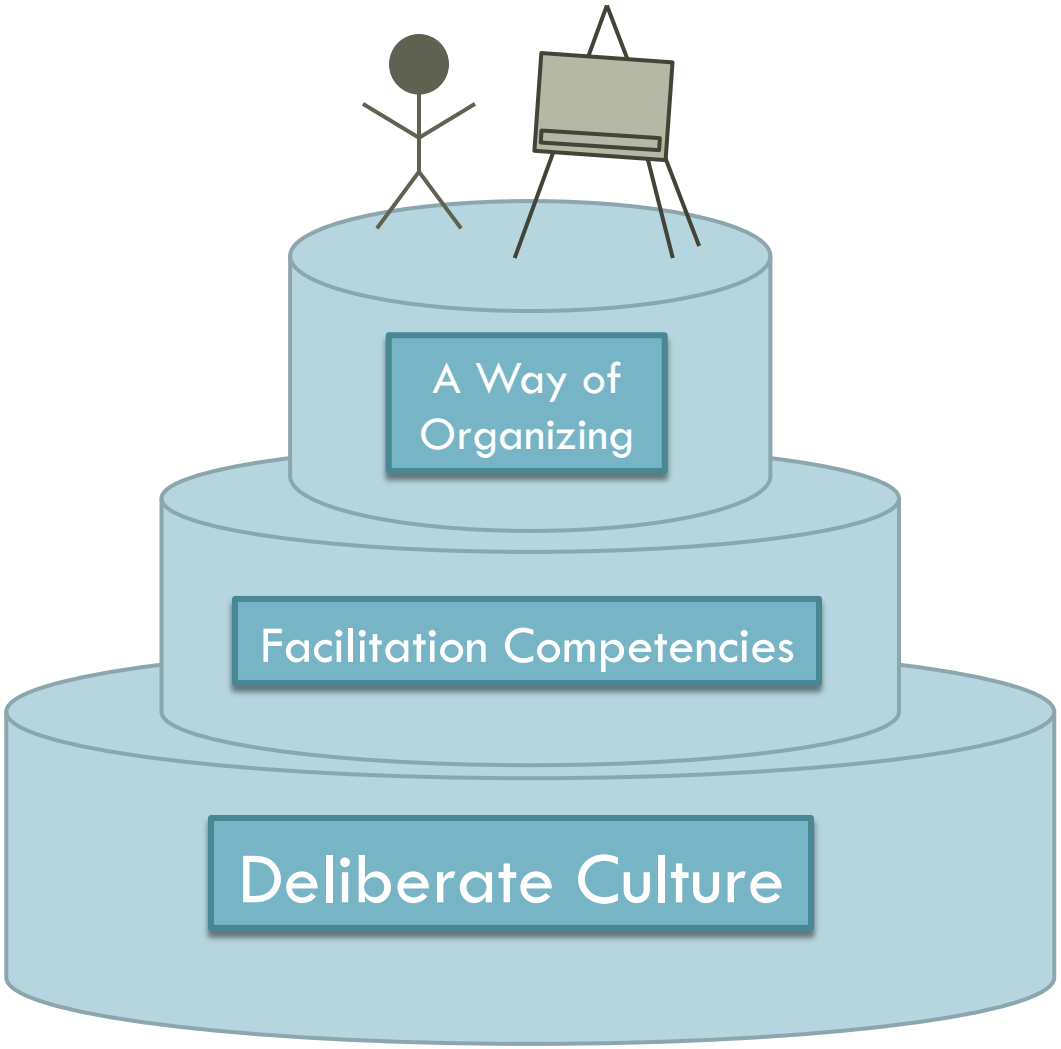

How we **demonstrate our culture** to the rest of the world
"Walking The Walk"

Our **espoused** values
The language we use to message our shared values
"Talking The Talk"

Our **shared understanding,** values, and principles.

Our assumptions about those we serve and the work we do

Cotton & Fox, 2011

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IN ORDER TO TRANSFORM THE LONG TERM SUPPORT SYSTEM EFFECTIVELY, WE MUST FIRST CREATE A PERSON-CENTERED CULTURE.

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Culture

"It is in the psychological process that culture has its ultimate power. Culture as a set of basic assumptions defines for us what to pay attention to, what things mean, and what actions to take in various kinds of situations."

- Schein (2004)

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Person-Centered Approaches Across Systems

- Developmental Disabilities
  - Self Determination
  - Person-Centered Planning
  - Individual/Family Direction
- Mental Health
  - Recovery
- Physical Disabilities
  - Consumer Direction
  - Independent Living
- Medical
  - Informed Consent
  - Informed Decision Making/Shared Decision Making
  - Slow Medicine
  - Hospice
- Aging
  - Person-Centered Planning
  - Participant Directed Services (Self Direction/Consumer Direction/etc)
  - Options Counseling

PERSON-CENTERED PLANNING ≠ PERSON-CENTERED SYSTEM

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Person Centered Planning

"Person centered planning is a process for developing a plan that is directed by the person and/or his or her representative and identifies the person's preferences, strengths, capacities, needs, and desired outcomes or goals."

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Purpose of PCP

Person-Centered Planning provides a clear structure for shifting the focus of planning and problem solving from program menus and human service solutions, to the broader perspective of individual's and family's lives and informal and community resources. It is a user-friendly process that builds trust and is conducive to cooperation and creativity.

Traditional Support Planning vs. Person-Centered Planning

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Traditional Support Planning	Person-Centered Planning
Decisions are to be made by "consensus" of a planning team that typically consists primarily of staff and professionals and are driven by medical needs	The participant drives decisions and invites people who they feel have important contributions to make, often including family, friends, community members and trusted allies from the service system
Professional conduct an assessment and determine needs	Focus of planning is defined by the desired outcomes of the participant
Focus of planning is primarily defined by a menu of service options that are offered under the HCBC waiver or other programs. Natural supports are sometimes used to augment programmatic supports	Informal and community supports are identified first. Programmatic supports are used to augment natural supports
Planning occurs periodically during annual meetings or isolated problem solving events	Planning occurs as a process that evolves over time
Attention is focused on problems and "fixing"	Attention is focused on strengths and "building"

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Principles of PCP

1. Individuals and their families are invited, welcomed, and supported as full participants in service planning and decision making.

2. Planning is responsive to the individual.

3. Services are flexibly designed based on the individual's needs, not on a menu of services.

4. Services are designed, scheduled, and delivered to meet the needs and preferences of the individual, not the service provider.

5. The system is committed to excellence and quality improvement through:
   affirming individual rights,
   protection from fraud, neglect and abuse, and
   being accessible, accountable and responsive to the individual.

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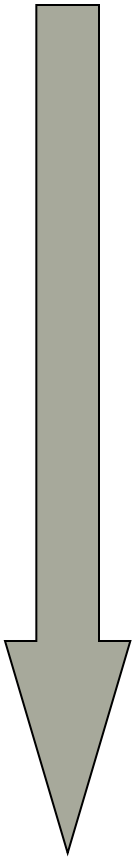
Serving Two Masters

Person-centered Planning

- Assess/Build Trust
  - Timeline
  - Relationships Map
- Explore
  - Routines Schedule
  - Preferences Map
- Decision Making
  - Pros and Cons
  - Priorities
- Commit
  - Back Up Support
  - Responsibilities Chart



System Requirements

- Medical necessity
- Assessment
- Intake
- Plan of care
- Service Arrangements
- Quality Monitoring

Outcomes and Goals

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Philosophical Guides to PCP

- PCP is a partnership, wherein the individual's values, desires, experience and knowledge are critical considerations
- PCP is, by design, a *process* that evolves over time; as a person changes, plans change
- Choice, Control and Dignity of the individual are the maxims
- Capitalizing on personal assets are critical considerations in the planning process

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Creating

The year - 2010

The program - NH Aging and Disability Resource Center

The funding- U.S Department of Health and Human Services, Centers for Medicare and Medicaid Services and the Administration on Community Living (formally known as the Administration on Aging)

The team - UNH Center on Aging and Community Living staff and the Person-Centered Hospital Discharge Planning Project Advisory Group

The what- a person-centered discharge planning tool for the individual and caregiver(s) to use when communitcating with primary care and other community care providers.

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Home and Community Living Guide

Important information about my needs, preferences and goals when receiving care

ServiceLink
Aging & Disability Resource Center

National Toll-Free 1-866-634-9412

Center on Aging and Community Living

This guide can help you think and share information **about you and your preferences, so that you can live the life you choose.**

This document will help you start an inventory of things you value the most, and give you a chance to reflect on your strengths and abilities.

By putting your preferences on paper, and reviewing this with people close to you, you can make sure that your for care are supported, when and if you need care.

This Guide can be shared with:

- Your doctor, nurses, or medical professionals
- Your spouse, family, or care partners
- Anyone close to you, and that you trust.

It is important to remember that asking for help is not a sign of weakness. Letting others know how you would like to receive help will support you to live the way you want, where you want.

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Your connections to people who support you help you to be successful in your community. This section identifies who some of these people are in your life.

Who are the people you rely on for help?

- □ Family
- □ Friends
- □ Neighbors
- □ Church
- □ Civic group
- □ _____

- □ Doctor
- □ Nurse
- □ Case Manager
- □ Personal Services (hairdresser, house keeper)
- □ _____

Do any of these people help you now?

Name Type of Help:

_____

_____

_____

Are there situations in your helpers' lives which may limit the kind of help they can offer?

- □ Small children
- □ Work demands
- □ Distance from me
- □ Family issues
- □ Lack of skill
- □ Don't know

Is there anyone who depends on you for help?

□ Yes □ No

If so, who? _____

One of the most important decisions you can make about your future is this: "Where do I want to live?" Our homes reflect our personalities, our life histories & what makes us feel safe, comfortable and happy. These questions ask you to think about & plan for your home.

You may like where you live & want to stay there forever - or not. Which of the following statements best reflects your attitude towards your home?

- □ This place meets all my needs.
- □ This place no longer meets my needs. It is too hard to care for, too big, too isolated. I'm ready to move—tomorrow!
- □ This place does not meet all my needs, but I am not ready to move at this time.
- □ This place meets some but not all of my needs. I think with some adjustments I could continue to live here.
- □ Other _____

What changes or improvements could make it possible for you to continue living in your home?

- □ Wheelchair ramp and/or wider doorways
- □ Bathroom with grab bars, other modifications
- □ Improved security or "Life Alert"
- □ Fewer fall hazards: less clutter/throw rugs
- □ Other _____

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Asking for help can be difficult when you need to seek assistance. However, it is very important that those who provide you care honor your choices and preferences in your daily routines.

How important is it to you that an individual who helps you with personal care, such as dressing, bathing, and help getting to the bathroom, be of the same sex as you?

- □ Very Important
- □ Somewhat Important
- □ Not Important

How important is it to you to choose what you wear?

- □ Very Important
- □ Somewhat Important
- □ Not Important

Do you have a dietary preference (low-fat, kosher, vegetarian, etc.)? □ Yes □ No

If so, what is it? _____

****

Daily Routines (cont'd)

What time of day do you like a bath/shower?

_____

What time of night do you like to go to bed?

_____

What time of day do you like to get up?

_____

Do you like to take a nap? □ Yes □ No

If so, when? _____

What other comments would you like to make about your personal care?

_____

_____

_____

_____

Please remember, this is your Guide. So if something changes in your life, or you just change your mind, be sure to update your answers to keep it current.

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Piloting

Phase 1: Active grant funding period- Pilot

- *Hospital Discharge Planners = tool is good but not their job*
- *ServiceLink Care Transitions Specialist= tool is good and will continue to utilize*

Phase 2Post- grant funding- outreach and pilot

- Manchester ServiceLink Resource Center
- Granite State Independent Living
- Concord Regional VNA- Hospice and Palliative Care program
- NH Office of Long Term Care Ombudsman

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Results/Lessons Learned- Phase 1

Hospital Discharge Planners- tool is great but it is not our role

ServiceLink Care Transitions Specialist- tool is great

Results/Lessons Learned- Phase 2

- 100% providers believed that the Community Living Guide was easy for his or her clients to read
- 100% providers stated his or her clients found the guide useful.
- Most participants stated there were no missing topics
- One provider stated: “[client] wanted to show it to her daughter” and “[client] thought it may be useful in facilitating conversation with doctor about the need for assisted living in the future.”

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Where are we now?

- Shifting from person-centered tool to care partner resource used to drive conversation
- Currently not measuring responses
- Using the tool to meet requests and gauge interest
- Care Partners want to utilize the philosophies of person-centered planning, but need unique support to engage with individuals.
- Tools like the Community Living Guide provide the structure needed to have difficult conversations

Long-Term Care Counseling

Nate Miller, LMSW

4/24/18

What is Long-Term Care

Long-term care differs from other types of health care in that the goal of long-term care is not to cure an illness, but to allow an individual to attain and maintain an optimal level of functioning….

Long-term care encompasses a wide array of medical, social, personal, and supportive and specialized housing services needed by individuals who have lost some capacity for self-care because of a chronic illness or disabling condition.

Who Uses Long-Term Care

- Annually 8,357,100 people receive support from the 5 main long-term care services; home health agencies (4,742,500), nursing homes (1,383,700), hospices (1,244,500), residential care communities (713,300) and adult day service centers (273,200).
- 68% of people 65 or older will need Long-Term Care Services.
- More women then men.

Who Pays for Long-Term Care

- Two thirds of Long-Term Care spending is paid by Public Funding sources. The largest source is Medicaid.

Long-Term Care Options Counseling

- LTC Counseling is a free service that provides information about long-term care.
- The trained counselor works with individuals and families to identify resources, supports, and services that will help meet the individual needs and goals of the person in need of support.
- LTC Counseling can be done for people in immediate need of services or for people planning ahead.
- Unbiased Independent Service.

Why is LTC Counseling Needed

- People who can privately afford LTC are in the minority.
- People are unaware of services and often have misconceptions about LTC.
- It is a complex and reluctant system.
- Multiple entry points.
- 14.8% of the 65+ population are below the poverty level.
- 1 in 3 Seniors develop dementia.

Limitations of LTC Counseling

- Legal Issues
- Financial Advice

Where to Access LTC Counseling

spectrum generations

AROOSTOOK AGENCY ON AGING

Southern Maine AGENCY On AGING
Creating Better Days

Eastern Area Agency on Aging
Serving Eastern Maine Since 1973

SeniorsPlus

Where to Access LTC Counseling

SENIORSPLUS : 1-800-427-1241
ANDROSCOGGIN, OXFORD, AND FRANKLIN

AROOSTOOK AREA AGENCY ON AGING : 1-800-439-1789
AROOSTOOK

SOUTHERN MAINE AGENCY ON AGING : 1-800-427-7411
CUMBERLAND AND YORK

EASTERN AREA AGENCY ON AGING : 1-800-432-7812
HANCOCK, PENOBSCOT, PISCATAQUIS, AND WASHINGTON

SPECTRUM GENERATIONS : 1-800-639-1553
KENNEBEC, KNOX, LINCOLN, SAGADAHOC, SOMERSET, WALDO, BRUNSWICK, AND HARPSWELL

Benefits of Planning Ahead

- Your choices are more likely to be known and honored.
- Less likely to feel overwhelmed when something happens.
- Relieves the burden on family.
- You are more likely to reach your goals and retain your assets.
- Improved health and safety.
- Increased Independence.

Maine Home Care

Kepro (1- 800-832-9672) determines medical eligibility (formerly it was Goold Health Care). Anyone can call for an assessment. If the caller does not have community MaineCare or LTC Mainecare, they may be subject to a wait list. Applying for LTC Mainecare triggers an assessment. If a consumer is already open to a program under Kepro's scope, Kepro will ask the coordinating agency to make the assessment referral. This includes homemaker services and skilled services with a home health agency. If assessed and found eligible for home care, Kepro will send the assessment to a care coordination agency, EIM or AlphaOne. The Office of Aging & Disability Services oversees all programs.

EIM coordinates home care services. Services, programs, and policies vary. Care Coordinators can work with provider agencies or offer self-direct options (PDO – Participant Directed Option) in which the consumer or family member (or other person depending on program) hire their own staff. This option is sometimes called FPSO, Family Provider Service Option, depending on the program.

AlphaOne coordinates home care services, mainly focusing on self-direction.

Estate Recovery applies to LTC Mainecare and Community Mainecare for individuals over 55. For more information refer to this page or call Legal Services for the Elderly 1-800-750-5353. Refer to Pine Tree Legal if consumer is under 60.

The **Long Term Care Ombudsman Program** (LTCOP) (1-800-499-0229 or 621-1079) provides advocacy, serving recipients of facilities, home care services, adult day services and homemaker services.

Homeward Bound is an option for people who have resided in a nursing home or hospital for at least 90 days, received MaineCare for at least one day in this setting and need nursing home level of care. For more information call LTCOP or consumers can also contact Frances Ryan, Homeward Bound Program Director, Office of Aging & Disability Services, Maine Department of Health & Human Services, 32 Blossom Lane SHS #11, Augusta, ME 04330 (207) 287-9233. By 1 year after returning home, the consumer will be transitioned to another home care program.

Copayment; PDN is up to $5 per month. HBC copayment is determined by EIM and based on income and assests. HCB cost-of-care is determined by DHHS OFI. **Spouse can be paid caregiver under HBC only**.

Other Options

If homemaking is all that is needed, referal can be made directly to ***Catholic Charities*** by callingl 1-888-477-2263 *(WAITLIST APPLIES)*

Medicare and some private insurances will pay skilled agencies for short term ***skilled*** services. This is for an acute need surrounding a medical event, loss in function or a transition back home. A physician must write an order.

Privately paying an individual or an agency is always an option.

If the consumer is a Veteran the ***VA*** may be able to help. Call 1-877-222-VETS for more information.

Revised 12/19/17

My Takeaways from Working in a Nursing Facility

- It's rare that people have private LTC insurance.
- Private LTC insurance doesn't necessarily cover all the costs.
- Living in a nursing facility is no one's first choice.

My Takeaways from Working in Home Care

- Managing disability and chronic disease successfully at home most often requires a mix of formal and informal support.
- Develop a back-up-plan – staffing is not guaranteed.
- There is no subsidized source for 24/7 home care.

Implications for the Future

- Studies have shown that the delivery of home or community-based long-term care services is a cost-effective alternative to nursing homes. Care in the home or community—not nursing home care—is what most Americans would prefer. Despite this, only 18% of LTC funding is allocated for community-based services.
- The aging of the population, especially those 85+—the most in need of long-term care—is expected to result in a tripling of long-term care expenditures, projected to climb from $115 billion in 1997 to $346 billion annually in 2040.

References

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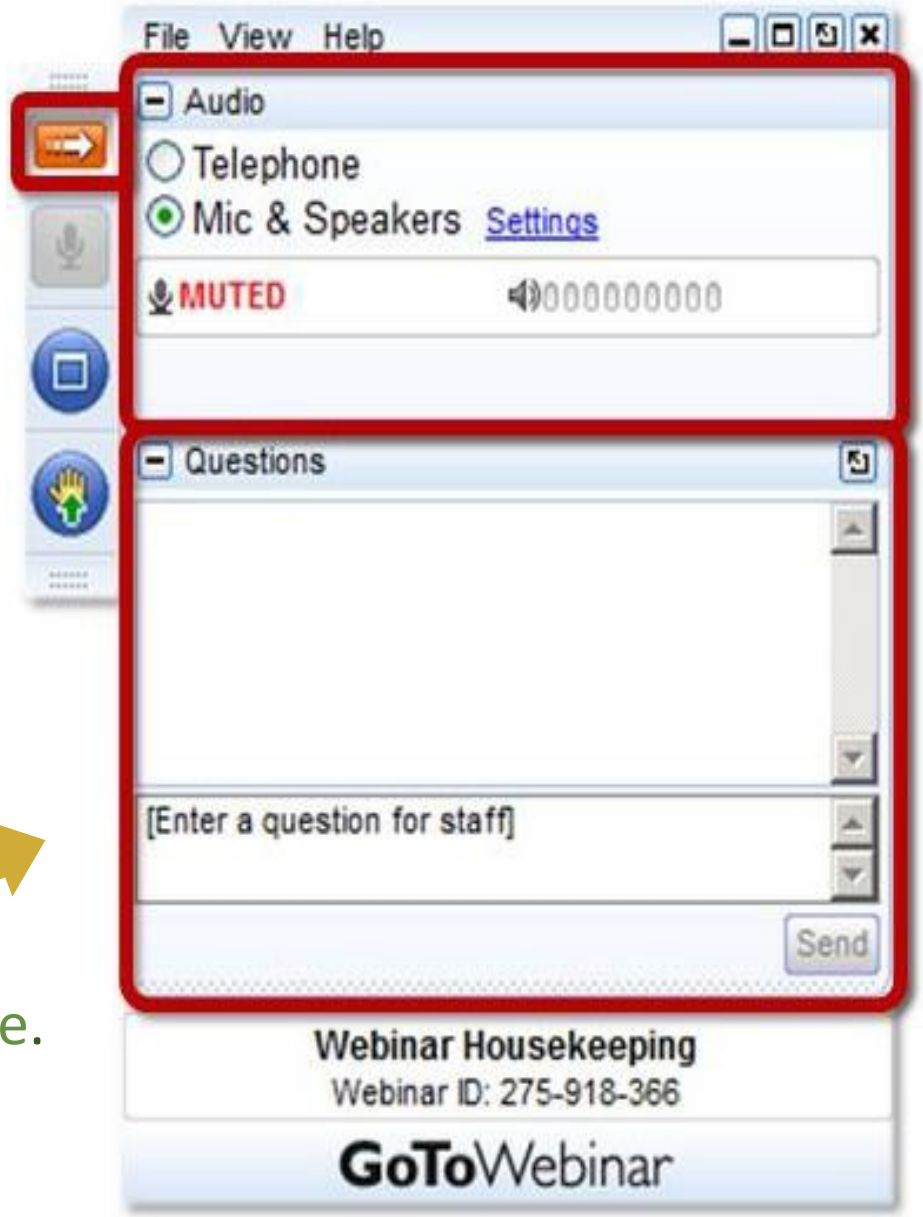
- Administration on Aging Statistics.
- Cost-effectiveness of Home and Community-based Long-term Care Services. Department of Health and Human Services: Office of Disability, Aging and Long-Term Care Policy.
- Alzheimer's Association 2018 Alzheimer's Disease Facts and Figures
- https://assets.aarp.org/www.aarp.org_/cs/health/ltc_resource_guide.pdf

Q&A with Speakers

To be **unmuted** click here & virtually raise your hand

Send **questions** to us by typing them in here.



Thank You for joining us!

- Slides & evaluation will be sent out later today.

- Recorded webinar will available within 24 hours.

www.agefriendly.community
patriciafkimball@gmail.com

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