

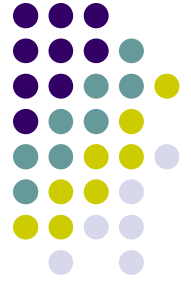
# Live Well At Home Project

(AOA-Funded Nursing Home Diversion Grant Project)

Arrowhead Area Agency on Aging  
Central Minnesota Council on Aging  
Minnesota River Area Agency on Aging

Minnesota Board on Aging  
**2008-2009**

# What is the Live Well at Home project?



- Federal, State, and Local Government's Vision:  
to create a person-centered, consumer directed long-term care system that helps people *at-risk* of institutionalization live at home for as long as possible

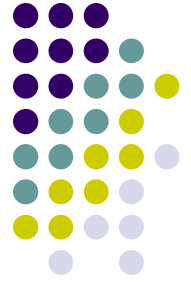


# Key Development Activities

- Create and evaluate new tool and process (*Rapid Screen*) to identify at-risk private pay persons at strategic LTC and health systems access points
- Create *new* diversion support service for *managing* risk factors and a competent, quality provider network
- Create access to *self-directed* support infrastructure

# Project Goal:

Target ***At-Risk*** Private Pay Persons with Risk Management and Self-Directed Support



- Develop consistent, evidence-informed process to identify and triage persons *at-risk* of NH/AL use and/or spend down to Medicaid.
- Link at-risk persons to flexible service and health promotion options to prevent or delay NH/AL entry and/or spend down to Medicaid.

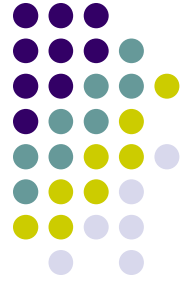
# Who is eligible for project?



Older adults who:

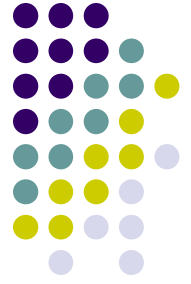
- Are 60 +
- Live in the greater Duluth area (*Arrowhead project*)
- May be at risk for moving out of their home.
- Are not eligible for publicly-funded Medical Assistance, Elderly Waiver, or Alternative Care programs.

# Project Components



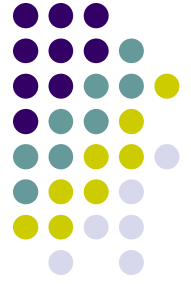
- I. Rapid Screen Service
  - A. Rapid Screen
  - B. Post-Screen Assistance
  
- II. Diversion Support  
(direct services intervention)

# I. Rapid Screen Service



## Rapid Screen:

- *Rapid Screen* critical domains
  - Assistance with  $\geq 2$  ADLS
  - Injurious fall
  - No family caregiver
  - Stressed family caregiver
  - Lives alone
  - + Memory
  - Planned housing move
- Administered by Parish Nurse, SLL staff, and other partners.
- Administered in the home with individual or their caregiver.
- Identifies individual risk factors



# I. Rapid Screen Service (*cont.*)

## Post Screen Assistance:

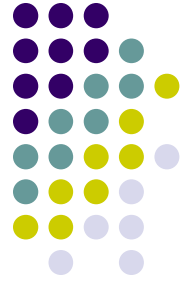
- 10-15 minute discussion following *Rapid Screen*
- Education about identified personal risk factor(s), impact and management strategies.
- Assisted referral for direct diversion support, caregiver coach, LTC Options Counseling, community-based supports.

## II. Direct Diversion Support



- Highly specialized, consultation and on-going follow-up for assisting at-risk persons and family caregivers *manage* risk factors
- Assist person to use *private dollars* to purchase self-directed community supports to delay and/or avoid nursing home and/or assisted living entry
- Provided by Arrowhead AAA Care Consultant-Mary Hellman

## Diversion Support Service **TARGETING**



- Risk Level: High-Moderate risk or any risk score with +memory issues
- Financial: persons with gross annual income between 200-250% Federal Poverty Guidelines (\$21,661 - \$27,075 individual)

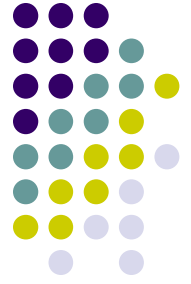
# Diversion Support Service **Essential Components**



- Education
- Recommended risk management approaches integrated with personal preferences
- *Risk Action Plan* development/implementation
- On-going risk screening and special caregiver and memory risk screens and assessments
- Direct assistance with referrals including consumer-directed infrastructure, specialty screens/assessments, and support.

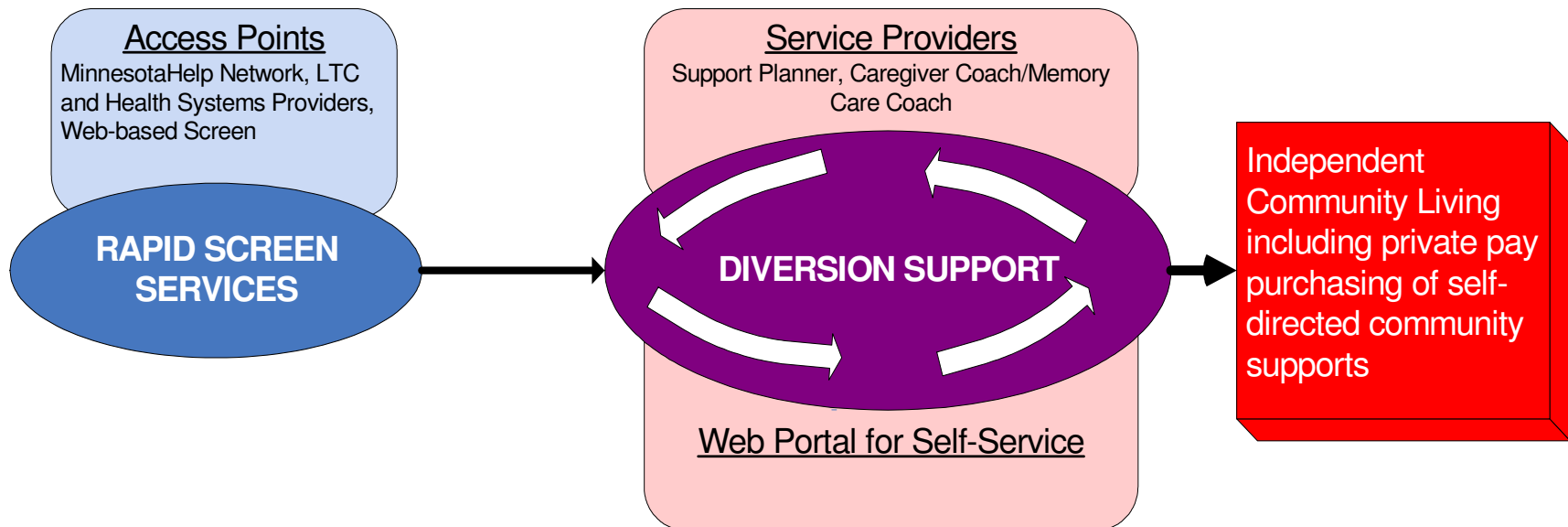
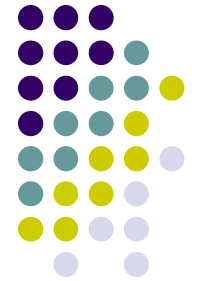
# Diversion Support Service

## Core Goals



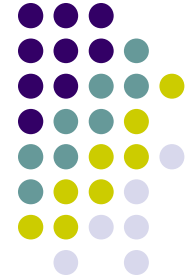
- Prevent imminent crisis event
- Improve and/or stabilize risk factor(s)
- Personal preferences, informal and formal supports, and purchasing power work in-sync to support independent living
- Informal support system intact – sustain caregiver
- Sustain community living

# Live Well at Home Model



Date: \_\_\_\_\_

Name: \_\_\_\_\_



### Live Well At Home Rapid Screen

1.	Do you need help to do the following? a) Walking b) Getting out of bed/chair c) Going to the bathroom d) Bathing e) Dressing f) Eating <i>IF 2 OR MORE CIRCLED → SCORE = 2</i>	<input type="checkbox"/>
2.	During the last 6 months, have you had a fall that caused injuries? Yes No <i>NOTE: "Injuries" means fracture or joint dislocation, head injuries resulting in loss of consciousness and hospitalization, joint injuries that led to decreased activity, internal injuries that led to hospitalization OR 3 or more of any falls</i> <i>IF YES CIRCLED → SCORE = 2</i>	<input type="checkbox"/>
3.	Do you have a family member/friend give you help because you need it? Yes No <i>IF NO CIRCLED → SCORE = 2</i>	<input type="checkbox"/>
4.	Does your caregiver feel overwhelmed or stressed because of the care they provide you? Yes No <i>IF YES CIRCLED → SCORE = 2</i>	<input type="checkbox"/>
5.	Have you thought about moving to other housing? Yes No 5a. If yes: where have you considered moving to? <i>IF ANSWERED "NURSING HOME" OR "ASSISTED LIVING" (i.e., HOUSING WITH SERVICES) → SCORE = 2</i>	<input type="checkbox"/>
6.	Do you live alone? Yes No <i>IF YES CIRCLED → SCORE = 1</i>	<input type="checkbox"/>
7.	Do you or your family have concerns about your memory, thinking, or ability to make decisions? Are you: Very concerned Somewhat concerned Not concerned? <i>IF VERY CONCERNED CIRCLED → SCORE = 2</i> <i>IF SOMEWHAT CONCERNED CIRCLED → SCORE = 1</i>	<input type="checkbox"/>
<b>TOTAL SCORE (SUM OF SCORES FOR ITEMS 1 THRU 7) =</b>		<input type="checkbox"/>
<b>RISK CATEGORY:</b> <b>0 = NO RISK; 1 = LOW RISK; 2 = MODERATE RISK; 3 and up = HIGH RISK</b>		

# Who are parish nurses?

Registered nurses –  
Special training



Works in faith community

Recognized sub-specialty practice of  
nursing *with the intentional care of the  
spirit.*

# Roles of the Parish Nurse

- H – Health Advisor
- E - Educator on health issues
- A - Advocate/resource person
- L – Liaison to faith & Community resources
- T – teacher of volunteers & developer of support groups.

H – Healer of body, mind, spirit and community.

(Canadian Association for Parish Nursing Ministry – 2005)

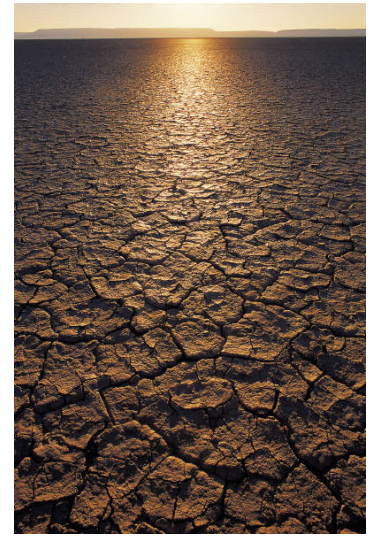
# Why were we chosen to partner?

- Trust levels
- Know our congregations
- Know the populations served
- Meet one parish nurse - You've met ONE parish nurse – same for the congregations served



# Characteristics of populations served

- Seniors in our pews.
- Independent
- Some that could fall through “cracks”
- Difficulty asking for help/assistance
- No immediate family in area



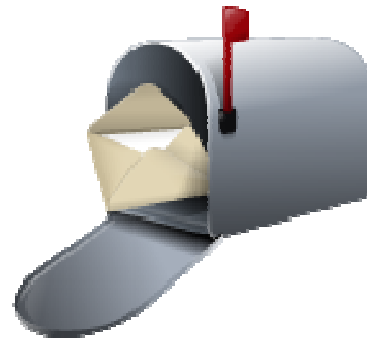
# How screen impacted work?

- To be an IMPACT - needed to “get-in” to person’s homes.
- Word of mouth – Friends.
- Called on - - Treats work.
- Newsletters – advertising
- Great Conversation starters for families.



# Process for Administration

- Time spent
- Listening to stories, concerns
- Empowered those – with praise for starting this process – giving kids peace of mind.
- Filled out and MAILED to ARDC office.



# Diversion Support

- Mary Hellman – AAAA Care Consultant
- Overview of Arrowhead Area Agency on Aging Diversion Support/Care Consultation Services
- Case Examples



# Contacts

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