ABCs of Nursing Home Transition: A Four-Part Webinar/Teleconference Series for New Transition Facilitators,

Part 3: Preparing for and Making the Move

presented by Bruce E. Darling on October 5, 2011

>> Female Voice: Good afternoon, ladies and gentlemen, and
thank you for waiting. Welcome to the ABCs of nursing home
transition webinar. All lines have been placed on listen-only
mode, and the floor will be open for your questions and comments
following the presentation.
Without further adieu it is my pleasure to turn the
floor over to your host Mr. Tim. The floor is yours.
>> Tim Fuchs: Thanks, I'm with the international counsels some
on independent living here in Washington, DC. I want to welcome
you back to part three of our webinar series. Today we're going
to focus on preparing for and making the move. This webinar is
being presented by the new community opportunities project. A
national training and technical assistance program of the
independent living research utilization program, ILRU in Houston,
Texas and the webinar was organized and facilitated by those of
us here at the National Council on Independent Living. Support
for today's presentation was provided by RSA at the U.S.
Department of Education. No official endorsement of the
Department of Education should be inferred. So as we mentioned,
today's call is being recorded and like the others it will be
archived on ILRU's website. And we will actually break several
times during the presentation today so you can ask your
questions. For those of you on the webinar you can ask your
questions in the public chat and you can type them in the little
TextBox underneath the immotor oh cons in the font and when you
type them you may not see them display but we will get themment
don't worry and then they'll show up when we break for the Q&A.
If you're on the phone today you can ask questions as
Brianna described and we'll remind you when we do that.
The PowerPoint (cough) excuse me, and the evaluation
form for today's call are on the training page that was
emailed to you. And if you don't have that URL, if you
don't have those materials, you're going to want to do that
now.
If you're on the webinar, of course, it's going to
display automatically for you, but if you're on the
telephone today and you don't have the PowerPoint you're
going to want to access that right away. It will make the
call a lot easier to follow. If you don't have that you can
email me at Tim at NCI L.ORG. TIM at NC I L.ORG and I'll
send it to you right now.
So anyway, if you would, please do take a minute after
today's call to fill out the evaluation form. It's very
short. And like I mentioned last time, there is an
evaluation form for each part. So you'll just be responding
to today's call. It's really important to us to know what
you think.
That's it for the housekeeping. I want to welcome
Bruce Darling back today. Bruce, thanks so much forfeiting
us into your schedule. And that's it for know announcement.
So the floor is yours.
>> Bruce Darling: Great. Thank you. Welcome back, everyone.
We previously had talked about putting the nursing facility
transition work in context, talked about identification and
Outreach, and assessment. Today we're going to talk a bit about
transition planning, addressing common barriers in transition,
developing and documenting a safety plan, and discuss the day of
transition. So we're on Slide four starting with the transition
planning process, the purpose is to work with the person to put
into place the supports, resources and arrangements they need and
prefer for community living.
Moving on to Slide five. This plan is based on the
needs we've identified during the assessment process. So
everything we talked about during the last session, you
know, you're now going to go and take those needs and
identify what services and supports are, you know,
necessary, and what does the person want.
The plan is developed by working with the individual.
The person's support network including family and friends,
community based providers and the facility staff. Now, I
think it's important to understand not everyone sitting at
the table is going to agree. And it's our job to facilitate
the process. And in doing that, it's helpful to understand
what's the perspective of the various people at the table.
Sometimes the nursing facility might have an attitude
where they're anxious about liability or a community based
organization is not as interested in picking up someone
because they're concerned about, you know, whether they'll
be difficult to handle in the community.
Your job is to sort of figure all of that out and
navigate through that of the and family, of course, is
probably concerned about their safety.
Moving on to Slide six, the components of the plan
include housing, personal assistance, assistive technology,
healthcare services, mental health and addiction services
and supports, transportation, volunteering education and
employment, family and friends, social, faith and recreation
and financial resources.
Yes, there's a lot there.
But each of these components we'll talk about is
really important to developing and putting together a
comprehensive plan.
So moving on to Slide seven. Housing.
The lack of affordable, accessible integrated housing
is one of the most significant barriers to leaving the
nursing facility.
So what we recommend doing is you begin immediately
exploring available housing options in the community, even
before the entire assessment process is done.
You may not actually have the complete plan for how
the services are going to be provided in the community, but
we all know there are huge waiting lists for affordable,
accessible integrated housing, so it's best to get your name
on the list as quickly as possible, because there will be
plenty of time to catch up with the rest of it.
Moving on to Slide eight. You need to put together a
realistic budget when you're developing housing. And have a
sense of what resources the person actually has to pay for
the housing.
What's the desired living arrangement, where do they
want to live? What are their accessibility requirements, and
are there any modifications that are going to be necessary
for them to live successfully in this particular location?
Security and utility deposits, you know, there may be
dollars needed to get those in place.
Furnishings, you know, it's not just an empty box.
You can -- although we have managed to set some people up in
pretty close to empty boxes, but you do need some basic
furnishings in order to have this.
And then providing assistance with moving. Those are
all things you're going to want to consider.
I think it's important not to assume where the
person's going to live.
A lot of times, you know, you -- you just sort of go
in thinking, well, everyone moves into subsidized housing,
maybe that's not the case. They may actually want to live
with family, or maybe they had housing that they want to
return to.
So, of course, we want to ask the person, you know,
what is their plan.
We want to provide options. It's not just a matter
of, you know, saying: Where do you want to live, and, you
know, having the person just sort of look at you and say,
oh, I don't know.
Let's give them options. Let them know what's out
there. And I think expanding the options beyond what you
might typically think of. You know, so, perhaps there isn't
available housing where you are located, but they have
family in another part of the State or out-of-state. That
might be an appropriate place for them -- for people to
consider.
So to throw that out on the table, not limit those
choices for people. Keep putting those out.
The availability is occasionally I alluded to the
availability of housing and services are going to be
critical and Mao impact this decision. So if you're in New
York City, there isn't a lot of housing available. It may
be important to look at where -- where you can find a
forwardable accessible integrated housing.
Similarly, if you're in an area where you can -- or a
state that you can't get good community based services,
moving to another state or a different place may be an
option for the person.
I also, when you're looking at housing, one of the
things that you have to sort of recognize is that the person
is starting over.
It's -- it's not fair. But it's just how it is.
So a person may have lived in a very nice place, in a
place in the suburbs and find now that they're extremely
poor and can only afford, you know, small subsidized
apartment in the city. It is sort of what it is. I think
in acknowledging that with folks, now, there are those who
are going to say I don't want that option, we still work
with them. It is their choice. So the individual is the
one who's in charge here. We can't forget that. But I
think it's important to give people nfld choice and give
them the variety of options that are out there and explain
the pros and cons of each of them and walk them through
that.
One other option that might come up is, you know, you
may actually be very lucky and for of it in to have housing
to go to. One of the women we've worked with had actually a
house that she had inherited. So she had a place where she
could go. The availability of services was the issue. And
she was actually able to barter rooms in her house to local
college students who assisted her with her personal care.
So we were -- she was able to use the housing as a way to
barter for services.
So I think the last thing on this side that I want to
talk about is, you end up having a lot of experience
understanding -- with connecting people to the housing and
identifying what the needs are. One of the things that we
don't often do, but we really should is take that experience
and use it to inform systems change.
So if you're working with folks, trying to get them
out of nursing facilities, and you find that housing is a
barrier pretty much like everyone else out there, one of the
things you can do is testify related to the consolidated
plan in your area. You know, talk about the need for
affordable, accessible, integrated housing and share that
with the folks who are doing advocacy, because it's -- and
get the folks you're working with to share their stories.
That can be really compelling.
So this is where the work we're doing in supporting
people in transitioning into the community can inform the
systems advocacy to make it easier for others to do the
same.
Moving on to Slide nine. Personal assistance
services. This is really the nuts and bolts of transition
for a lot of folks. If you can nail down the housing the
personal assistance services is going to be the next big
piece of the and you want to look at from your needs
assessment identify what's available to meet those needs.
You want to look at formal services. What formal services
are available.
And those may include certified home healthcare,
personal care, services under waivers. They may have lots
of different names. They may be available through a managed
care organization.
It's important when we're doing transition to know
what the formal services are that can support an individual
in the community.
We also want to look at the informal supports that are
available.
So, sometimes a person may have family who can assist
with something or friends, you know, some of our most
successful transitions have been where a devoted family
member or friend was able to fill in a vital support that
allowed everything else to function well.
So that's a big piece you want to look at as well.
What informal supports are out there to assist the
individual.
Training needs for managing attendance are important
as well.
Now, a lot of times in independent living we think of
people giving training to manage attend dandz in a training
area where they supervise all those functions but we think
it's also porn for folks moving from a setting where they
have no control and services are done to them, in into the
community so they get some training and support as well in
managing their services and identifying their needs.
Because now you're in a very different position when you're
in the community even t you're getting services through a
traditional agency you have a much more active role in that.
So training is important during this part, this phase.
You also want to identify additional gaps that need to
be addressed.
Maybe you have all of these pieces, and the person
needs something that's not -- that you don't know how to
fit.
Well, in New York, as an example with the formal
services we were able to get assistance for folks who had
hands-on personal assistance needs, but if they were just
sort of needed someone, as they call safety monitoring, to
hath out and make sure they were okay, only in certain
circumstances were we able to get those.
So it had to be a very particular -- you know,
essentially if you didn't have a brain injury or
developmental disability you didn't have that service in our
state.
So we had to rely there very much on informal supports
or there are other little tricks that we could do in terms
of trying to address it, but it was a real problem for us.
This is where, using our experience with the service
systems could inform our systems advocacy as well.
Here in New York what we did was we identified that
this was a significant problem, particularly people with
dementia, people over 65, people who had MS, people who
needed that extra piece of safety monitoring, and we were
able to use that to raise the concern with the state as an
Olmstead issue and create a new waiver program.
Now, take -- obviously it took us like five years.
But it is something where, doing the work you actually learn
a lot about what needs to be done and you can use this to
inform your systems advocacy and inform the state as to how
they can better comply with Olmstead. But you want to day
all these pieces together, to put together personal
assistance services that will support the individual in the
community.
Moving on to the next slide. Slide ten. Assistive
technology. Hearing aids, other am public fifth cake
devices, easy for me to say. Environmental controls,
toilets and showers equipped with grab bars, door levers
instead of knobs. These are all things you want to look at
in terms of what does the person need to be able to live
effectively in the community. And I think one of the things
that we're really good at within the independent living
community is looking at low-tech and inexpensive solutions.
Honestly I think, you know, we were the people who
came up with the concept duct tape solves a multitude of
problems. In terms of accessibility and assistive
equipment. You know, a person -- I don't know, that was my
background. We didn't have a lot of stuff, you know, back
in the day. You needed to just come up with it on your own.
So some -- someone needed a fork that they could actually
get a grip on? Duct tape solved a lot of those problems.
Supportive neighbors can be very helpful.
Particularly where you have people with disabilities who are
committed to supporting each other in the community. They
can be vital support. They're not a -- they're not
technology, but they can be very vital, and they can
actually offer suggestions as well.
And, you know, having a handy family member is not --
you know, a problem either. It's very helpful, in fact.
My father, who has since passed away, was very, very
helpful. He was really, you know, good with making things.
So I would come to him and say: Hey, we have this problem.
I need something to do, such and such. And he could
actually create something, and it was on more than one
occasion where a specialized contraption that he put
together was able to help a person move into the community.
So looking at those kinds of things, those resources
that you have, are really important to making this work.
Slide 11.
So, with healthcare, we need to have general medical
care, is important for people. So the Primary Care
Physician, the dentist. But when we're looking at a Primary
Care Physician, you know, it's not just will they accept
Medicaid, which is often a -- one of the first hurdles you
have to get past. Whether they have any experience with
people with disabilities -- but you're also going to look to
see whether they have the right philosophy as well.
So, you know, for us, it's the tale of two doctors.
We had one physician who, you know, when we were all
young and kind of healthy, he was really good at working
with us. He listened, and we found him to be very
supportive. But as we got older and folks began to have
more issues, and there was the risk of institutionalization
it suddenly became clear that he -- although he felt it was
great for active people to be involved in the community, he
wasn't so if you remember on this applying to everyone. And
he started to talk about how people needed to go into
nursing facilities and how they needed to accept that
choice.
Basically what happened is a whole bunch of us left
him, one right after the other.
I'll contrast that with another doctor.
She -- we got a call, a woman with MS was being told
that she needed to go into a nursing facility. And which
you willy her lawyer said: Could you go and do a protest?
And we said, wait. Maybe what we could do is just get her a
new doctor. And we connected her up with this sort of Earth
mother doctor who worked out of a local clinic that accepted
Medicaid. Great woman. And although this person -- the
person we were referring had difficulty speaking, her
attendant could understand her. The home care agency who
was trying to get her out of their hair forbid the attendant
from going into the doctor's office so this doctor did the
interview in the parking lot with the attendant there,
preserving her job, went in with the woman and did the exam
and did the debrief in the parking lot as well. Now, don't
suggest that you should have to get your medical care in the
parking lot, but what you want is a doctor who's committed
to do what it takes to keep you in the community. And this
doctor was clearly one of those folks.
So looking -- the question then becomes how do you
find these people? They exist and I think our centers are a
great resource on this. If you just talk to folks you can
begin to find out who are the good docs, what do they know
it? And that network that we have of sharing that
information is really very helpful.
Specialty medical care is also important. People have
a lot of medical issues, urology, orthopedic, you need to
pull all of those folks in and then finally durable medical
equipment. All of that kind of falls within the healthcare
category here and are things that we need to be pulling
together for folks.
Moving on to Slide 12. Mental health services and
supports.
We need to address the needs identified during the
assessment. So a person -- you may have identified that the
person has needs related to a mental health diagnosis. Do
they need psychiatric services? Maybe peer counseling?
Crisis enter Convention services for folks, maybe they have
an anxiety disorder and they may need some crisis
intervention. You know, there are alternatives to the
Emergency Room where people can get peer support, you know,
during off-hours. Those kinds of services out there. Work
those into the plan. I think it's important that we
approach those up front and say: Look. It's not -- if you
expect that there's a potential problem, plan for it, so
then when there's a problem -- when that happens it's not a
crisis, it's just something you do as part of the plan. And
then medication, as well.
Now, I think it's important that certain mental health
needs may be exacerbated or masked by institutionalization.
So maybe a person -- you know, a lot of times people
in nursing facilities seem depressed. Well, they're locked
up.
I would be depressed if I was locked up of the and
when they return to the community they may not need
medication as much for that type of thing, because, well,
it's situational and it's gone away alternatively the
structure of the setting may have actually masked some other
symptoms and issues that are going on for the person.
Maybe they're not as stressed because they have that
structure and the stress of moving is going to be difficult
for them.
You want to plan for that.
I believe this is where you have one of those heart to
heart conversations that we've talked about during the
assessment process, and talk through with the individual:
So what do you, you know, what do you think we need to do to
address this issue?
And walk through those options with them to identify
what cundz of services and supports can be put in place.
Moving on to Slide 13. Addiction services and
supports.
Now, addiction may have been the cause of the
institutionalization in the first place and they can have a
significant impact on the transition.
In fact, one of the guys that we worked with in
transitioning, the primary reason he ended up in the nursing
facility was that he had blacked out from being an
alcoholic, and ended up -- had some health problems. Ended
up in the nursing facility and then got stuck there.
Now, a mauzingly, physical assistants were
extraordinarily limited. I would argue he was more
physically able than I am. But he still ended up being
stuck in the nursing facility and one of the primary issues
really related to the addiction.
So working with him and talking that through and
coming up with a plan.
One of the things that, again, being in a facility
means you may -- you may have less access to drugs or
alcohol in the nursing facility. So that that would be
something if a person has a history, talking through and
working with them and identifying what services and supports
they might need, and putting those in place.
And these might include treatment, counseling or
12-Step program.
So just sort of working through with the individual.
And again, they're in charge of the process, but helping
them identify: What do you think we'll need when we move
out into the community? And having that conversation, well,
you've not had a problem drinking here in the facility.
Moving out, it may be more difficult. Do you think we need
to put something in place? Or can I connect you up with an
AA group or something?
Now, one of the things that complicates this
particular issue is that some of our folks actually are
abusing prescription medications.
And we're not buying off the street. We're actually
getting it, you know, from Medicaid.
So, you want to be on the lookout for that type of
thing.
And -- and have -- and recognize where there might be
an issue with someone who's abusing prescription
medications, and have that conversation as well.
Again, building from that assessment process where
you're getting to know someone and having those discussions,
again, I think it's important that we not apply a judgment
to it. We're just saying, look, these are the things that
we can do to put together -- our goal is to make the
transition successful, not to change who you are.
Moving on to Slide 14.
Transportation. Now, access to transportation is
going to affect your housing choices as well. So you can
see how a lot of these pieces all begin to -- to fit
together. Housing services, transportation.
And, you know, depending on where you are, you know,
your options may include Medicaid transport, as long as
Medicaid is still paying for those things, public
transportation, including paratransit or maybe they have
their own vehicle, do they need a lift equipped vehicle, are
they able to transfer, how frequently do they need to go
places? Do they need to be at a particular -- to go to a
particular place on a certain frequency.
So, for example, just taking it out of this context,
you know, in college I -- I didn't learn to drive till much
later in life.
So I needed to go to particular places. That limited
my housing choices, because I wanted to be on particular bus
routes.
So you want to think those types of things through.
Now, when you're talking -- when you're moving to a
more rural area, maybe a person has the resources available
informally where there is informal transportation to get
where they need to go. They may need to consider moving
into a more urban setting or a place that has more
infrastructure to support them in terms have they may really
want to live, you know, in the -- in the mountains, but
can't really make that work, because they need
transportation that's just simply not available.
So that's one of the things you want to work through
with the individual. How do you balance those needs.
15. We talk about looking at volunteering, education,
and employment.
You want to work with the individual to identify
meaningful daily activities and incorporate those into the
plan.
Now, when I talk about meaningful, it's meaningful to
the person, not to you as the transition facilitator. So
what is it the person wants to do? What do they want to do
with their days?
This -- this -- this may -- this part may be developed
later, but it's still important to talk about these issues
even if the person is not ready for employment or education
or even volunteering.
What does the person want to do with their day? Aside
from get out of the nursing facility?
So I mean, people may be very interested in reading,
you know, connecting them up with, you know, at least having
the conversation. Potentially connecting them up with a
book club or, you know, helping them connect up. Where's
the library, what can I do? Those types of things. What's
important to the individual and how can you work that in.
But, again, a lot of times folks are just very focused
on the transition process, and need to focus on that. So
this is sort of a -- an ice-breaker conversation for
something that may come later.
Slide 16. Family and friends.
Family and friends are important. A good support
system can help with significant -- with a significant
adjustment from the institutional setting to the community.
Now, I think it's important to recognize that people
who have identical needs but very different amounts and
types of informal support can have wildly different plans
and outcomes. That's how important this is. So sometimes
the success of a transition or the ability to make it, you
know, work smoothly is really built on this particular piece
that comes from family and friends.
Moving on to Slide 17, you want to build support for
the plan with the family and friends. And again, you're
working with the individual. You know, you're taking your
lead from them.
You know, if they -- you don't want to force they will
into a relationship with family and friends who they're he
is stranged from, you know, but if family and friends are
important, and they have resources, you want to work that
through.
Family and friends may have some significant concerns
that you've identified during the assessment process. It's
important to address those. You just can't sort of ignore
them.
So, what -- you present them with solutions but you
don't want to be held hostage to that process either. You
can get into what I call a yes, but game. So they say I'm
concerned that, you know, Ralph is going to not be able to
get in and out of bed. And you talk about how there's a --
we have a transfer boards, and these are the kinds of things
that -- therapy he's getting in terms of building his
ability to transfer. We have attendant services, there's
all this adaptive equipment services, you need to talk that
through. Well, yes, but I think that the problem is really
this other thing. You really can't allow people to get too
much into that. You want to have the -- you want to get
them to put their concerns out on the table all together so
that you can -- instead of it being an incremental -- they
raise a concern, you solve the it, they raise a sifrt
concern, you solve it. And then that can become an endless
game of yes, but. The idea is you get stuff on the table.
You want to address their real concerns and support them.
Because if they're concerned often they want their family
member to be safe. You don't want to have their family
member be unsafe.
So find a Common Ground and work together.
Moving on to Slide each. Some strategies that can be
helpful with engaging families are communication. Okay?
That sort of seems obvious, but it's important. Talk to
them on the phone. Communicate by email. Meet the folks in
person. I think that that's really important, because they
can actually, when you're meeting in person, you can get
a -- email can be a little bit cold and people can misread
what you type. When you're in person they can see that you
genuinely care about the individual. And because like -- of
the background we have, we work directly with the
individual. You're not likely to see that sometimes with
other professional folks.
So, they'll see us a little bit differently.
Plus, a lot of the times folks in our centers have
disabilities themselves, and when they meet you in person
they think, wow, okay, he knows what he's talking about of
the look. He's -- he has an attendant hills. So it's not
like he's just some sort of person who's talking about
something that he doesn't know about.
So, really, communication in person is very helpful.
Involve families as much as possible during the
planning process, again, with the person who you're
assisting, giving you the direction on that.
So, it's -- if they're involved in the planning
process and you're communicating what's going on, I think
that that goes pa long way to getting their buy-in and
support. And being direct and honest. I think, you know,
if there's a concern that they have, you know, address it
directly. Don't answer around it or, you know, try to floor
it up. Be direct and honest. You can say there are some
situations that don'tal up frequently where we do have
issues that are concerns. You know, we have had some
concerns about home care in the past. This is how it's
different.
Put the information out on the table for them.
And while it's important to involve the family, and
I've talked a bit about informal supports being
extraordinarily important, I think we also want to balance
their concerns and what they have to be able to offer one of
the things I see is is services, they lean on the family for
informal supports where formal supports could be put in
place. They see the family as a group of people who can
offset cost. They're a cast saver, so the family is going
to provide this level of service. Our experience can help
understand where the line really is and what's available.
So sometimes these provider groups will say: Well, Mary, I
know that he requires someone, you know, John requires
someone to stay up all night with him and make sure he's
okay. You can do that. Right? Now, if Mary is really
invested in getting John home she may say yes, when you're
thinking to yourself, but when does she sleep? You know, she
has a jobment I don't see how this actually works. So
having that conversation with folks and making sure you have
family on both sides, those who are really anxious and not
wanting to do something and then those who can easily be
taken advantage of. You want to work with them to make sure
that when you have a plan, that they're not railroaded into
doing something they can't sustain long-term.
Moving on to Slide 19.
Social face and recreation are important to folks.
So a lot of folks their faith community is deeply
important to them. And that may affect some of the housing
choices, it may -- you know -- you may want to actually
involve folks, you know, look at where their church is or
their synagogue and connect them up. This also -- this
section also provides an opportunity toll connect them with
old friends and people who can be supportive during the
transition process.
So it's not just that you're planning for their future
recreational stuff but whether they go to church. It also
gives they will an opportunity to rebuild pieces of their
life and the connection that they had. And you want to
develop a plan to support the wreck yeah activities, and
that could include things like transportation and personal
assistance. So if they need assistance during the day to
move out, to go out into the community, then you're looking
at making sure that that's incorporated into the plan
somehow.
So moving on to Slide 20. So I've talked pretty much
everything except money. Which we know is extraordinarily
important. So if you don't have the money to pay for some
of this stuff or to get the services paid for to pay for the
housing, the plan doesn't actually work.
So having adequate income is essential.
Some of the critical activity that you're going to do
around this are filing the change of address. So when a
person is going to move, you need to notify Social Security
and such that they're actually moving. Sometimes the
facility will be receiving the payments directly. You'll
want to change that over. And you can actually change the
payment over to the individual before the individual moves
out of the nursing facility, so that the nursing facility
doesn't have to accept -- take their funds directly.
You want to -- if the person doesn't have any income
you need to apply for Social Security or SSI or SSDI.
Yeah. Okay, you're thinking how can someone be this
deep into the system and not actually have basic financial
benefits? It happens. The first time it happened with us, I
was stunned, I just couldn't believe. But the woman had
money that she received from her husband as part of a
divorce. So she had that money coming in. It never
occurred to her that she should apply for public benefits
and that she would be eligible. And in fact, she was.
So -- but the point where she's moving out into the
community, having access to those dollars was very
important. So that was one of the first things we did with
her.
If the individual has SSI, you know, we assist the
individual in notifying Social Security about their change
of address, their change of status because the amount of
money that they receive is going to change when they move
into the community.
Moving on to Slide 21.
Apply for food stamps, other financial benefits. I
think this is really -- this is where having folks who know
what resources are out there and available is really
important. You can actually sit down with folks and find
out that, well, you know, you actually are eligible for some
additional money. Sometimes there's food stamps, HEA P,
home energy assistance programs we have here. There's
dollars that you can coddle together. Maybe this one piece
of income doesn't cover everything, but when you start to
put all of these pieces together, you have what you need to
support the person living in the community.
And complete the paperwork for community Medicaid.
The rules in the community institution are different. So
you want to actually, you know, make sure that when you're
going from the institution into the community that you make
the transfer over so that they have community Medicaid
'cause institutional Medicaid doesn't pay for the stuff we
need out in the community.
Moving on to Slide 22.
So, as we're talking about money, look, there we go.
As we talk about money, you know, we'll need to set up a
monthly budget. So does the budget support paying for the
necessities and the things that the person thinks are
important, okay, in this case, I think, honesty is
extraordinarily important.
My own personal experience is that a budget you don't
follow is completely useless. I have done this multiple
times for myself.
Why put together mu plan for how I was going to live
or maybe it was a meal plan for how I was going to eat of
the and I completely ignored really important things to me.
And it just was doomed from the start. It wasn't
going to work.
So what's important to the person?
I worked with a woman, an older woman, who's really
one of the most -- things that was most important to her was
a weekly hair appointment where she got her hair done. I'm
one of these people who is less attuned to these things so I
get my hair chopped at super cuts whenever it occurs to me
that there's a problem. So her having that weekly pointment
was really important. It Maud her feel good. It was a part
of her schedule. And take -- and saying, you know,
developing a budget that didn't include it wouldn't work.
She would still find a -- you know, even if we put all the
money into the food, she would not buy food in order to get
the hair appointment. So rather than having the person try
to figure that all out and work around the budget, you work
with the person to develop something that's going to make
sense.
Some things you might consider are other resources
available for the person. We're talking about starting
over. Sometimes family and friends actually pitch in to
help float the boat.
We've all -- I think at least a lot of us have
experienced that, we do that for other people. This may be
something to consider and put on the table.
And one last detail is to actually have some cash on
hand for the day of the move. I don't know, not talking a
huge amount of money, but sometimes, you know, the microwave
is somewhere in a box or in transit somewhere. The person
needs to eat something. You're hungry. Everyone's crabby,
having some money on hand to be able to order some pizza can
solve a multitude of problems.
So having some cash on hand is important on the day of
the move.
So, what I'd like to do is move to Slide 23 and open
this up for some questions and answers.
>> Female Voice: The floor is now open for your questions.
If you would like to ask a question via the telephone please
press the number seven or the letter Q on your telephone keypad.
Questions will be taken in the order they were
received. If at any point your question has been answered,
you may press seven or Q again to disable your request.
If you are using a speaker-phone, we ask that while
posing your question, you pick up your handset to provide
favorable sound quality.
Again, if you do have a question, please press seven
or Q on your telephone keypad.
(Pause.)
>> Female Voice: Please hold while we wait for the first
question.
(Pause.)
>> Female Voice: Again, if you do have a question, please
press seven or Q on your telephone keypad.
(Pause.)
>> Female Voice: The first question comes from Barbara
Elliott. Barbara, please go ahead.
>> Female Voice: The guidelines of how and what to do, 3 to
6 months prior to the move date, and what is the timeline for
transitioning from a nursing home?
>> Bruce Darling: Okay. I'm sorry. I didn't catch the
beginning of that. Could you repeat the question for me?
>> Female Voice: Guidelines of how and what to do. Is it 3 to
6 months prior to move date? And do we have a checklist of do's
and don'ts to do? You know, contacting services or people or
having these conversations with the client?
>> Bruce Darling: Okay. Sure. I'll talk a little bit about
checklists, but I -- basically, going -- when you go through the
list of things that I've talked about, each of those is something
that you want to discuss.
And I was actually recently asked if there was a way
to sum mrif Phi the process and make it a little more
efficient. Actually, the comparison was like you could be
the Henry Ford, Bruce, of nursing facility transition if you
could make this simpler. Unfortunately I've been thinking a
lot about that concept, but a lot of the time you're dealing
with very unique situations and individuals.
There's a lot -- there's some common threads on
things. But each transition is going to be different based
on the person's personal -- personal experiences and what's
going on.
So we've had transitions that have been very, very
quick, because housing was in place. And it was just a
matter of getting some services approved.
And they have a lot of other pieces.
Where you're building something, you know, if a
person's been institutionalized for a long time, doesn't
have a lot of services -- you know, family and formal
support it may take much longer. One of the things that we
do when we first talk to a person is tell them that, you
know, based on their situation it could take, you know, six
months or even a year to get out of -- into the community
depending on how long the waiting lists are for housing and
such.
We talked a bit the last time about the assessment
process, and that, so, you know, I think that that -- those
initial meetings sort of cover that piece.
There are some checklists and things that I'll talk
about later where you can go to, but I think my personal
experience is, if I tell you that there's a specific
timeline it's going to vary pretty dramatically depending on
the individual's situation.
>> Female Voice: Thank you, Bruce.
>> Bruce Darling: Oh, thank you.
>> Female Voice: Again, if you do have a question, please
press seven or Q on your telephone keypad.
(Pause.)
>> Female Voice: Did you want to go to some web questions
while we wait for some moreover the telephone tum Tim perfect of
the thank you. I just have one right now, Bruce, Sharon is
wondering what paratransit is.
>> Bruce Darling: I saw that pop up. And it distracted me for
a moment. My bad.
Paratransit is the alternative to fixed route buses
that public transit authorities provide. So you have public
transportation and fixed route buses they're required to
provide paratransit for folks who can't use the regular
fixed route bus. So that's a transportation option. And
for some of the folks that we're working with, getting that
para -- you have to be approved for paratransit, getting
that application apply -- you know, done, is one of the
first steps we do in transition, because we -- that actually
lays the groundwork for doing some of these transition
planning meetings at the center and having the person get
out into the community.
>> Tim Fuchs: Okay. Great. That's the only web question
right now. So let's check in with Brianna one more time. And
then we can go back to the presentation.
>> Female Voice: As a reminder, if you do have a question,
please press seven or Q on your telephone keypad.
(Pause.)
>> Female Voice: It appears we have no additional questions at
this time.
>> Tim Fuchs: Okay of the thanks.
Bruce?
>> Bruce Darling: Wow, I'm stunned. And I know I didn't cover
this in that much detail, because I can do this in like two days.
I just -- before we move back in, I want to go back
to, is it that the question of the standard kind of -- is
there a timeline, there are some unique resources available
or some checklists available. There are -- if you do some
web searching, there are a lot of approaches out there for
doing this kind of work.
Because the programs and services that are available
in various states vary dramatically, and the circumstances,
you know, whether you're living in a highly urban area or a
rural area, because all of these things are so open, I can't
really give very specific answers to these transition
questions.
I like to point out though that wherever you are,
although there are things that are potentially more
difficult, you have things that are actually easier.
So, for example, in more rural parts of our state you
may have a harder time accessing services because they're
not as available. But what we find is the building code
people are a lot more lacks, and you can get away with a lot
more stuff in terms of making moldifications to your home
more informally than you can in a more urban setting, and
that there is a different attitude sometimes. You may have
more connection to folks and things that you can do. You
can do things a little bit more differently.
And, you know, for example, you may have other options
available. A friend of mine whose niece has a developmental
disability, her -- she -- in an urban setting, traffic
safety would be a potential issue for her, but a moped out
in the rural area where she lived was very, very effective
at giving her an opportunity to travel around.
So, I think it's important for us to look at what the
opportunities are for us where we are and not just look at,
you know, what the barriers are.
So moving on to Slide 24, having said don't look at
the barriers, there are barriers obviously, when you're
working with folks and there are some common things that
we're going to run across, which just happen pretty
frequently.
So potential barriers include unpaid utility bills.
Often times, you know, even if folks didn't have a bad
credit history, something happened, and they ended up in a
nursing facility. Maybe there was some sort of, you know,
some sort of significant health crisis. A lot of times in
that situation bills don't get paid.
So even if they had a stellar record prior you may
find that they're in the nursing facility, people thought,
well, you know, Betty's going in the facility, who cares,
we're not paying that. Or, you know, Robert, you know, now
that he has a spinal cord injury, that car that he had is
not very helpful to him so we're going to let them talk it
back. So you can find that credit issues are going to be a
problem and utility bills. So some solutions on this are,
work on a payment plan to clean that up, particularly for
things like utilities. If you need electric or telephone,
and you have those unpaid bills is it possible to arrange a
payment plan? Even a very small amount of money if you
explain the situation. Can we put that on plan to solve it?
Can family pitch in? Or, you know, the church? Are therein
formal supports that can provide some funding to help clean
that up.
And maybe a letter from a doctor. That talks about
the medical necessity.
A lot of times folks are particularly concerned about,
you know, electricity and telephone.
So that the individual, you know, the -- need the
electricity say for a ventilator, motorized wheelchair,
telephone to be able to call for help with the person,
personal emergency response system. Those are things that
you can get a letter from the doc to say, hey, this is
something that we need.
If you have a bad credit rating or a poor rental
history, you know, cleaning that up. One solution that we
have proposed to folks is identifying a representative
payee.
So we had one guy who had serious, serious credit
issues that went back a long time. And, you know, he found
out -- he ended up in the nursing facility when he found out
that she whose name is on the lease gets control of the
apartment, even if it is fully accessible, and she's keeping
it to spite you because you were a dog.
So he ended up in the hospital, and then in the
nursing facility, because she threw him out.
So he couldn't get an apartment on his own. He had --
he had blown his credit.
We had said, you know, as an alternative, you get a
rep payee. And we suggested and that seems a little odd
that we would suggest this, give control over to someone
else, but what it did was it cleaned the slate for him. And
we said don't go to an agency where they're going to get
control of your money and it's going to be like a machine.
Identify someone who's willing to do this for you and work
with you, you know, so -- 'cause this doesn't need to be a
lifetime decision. You just need to be able to make this
work.
So identifying someone who could serve as a rep payee
could clean that up.
Criminal convictions and I stress the word conviction
here, this can be a potential barrier particularly around
accessing housing. It does significantly affect the housing
options that are available to you.
And then a history of noncompliance or issues with
home care.
So, if you -- when you were in the community, you
weren't at your home care appointment, you know, people, the
attendants would come and you would just not be there. Home
care agencies don't like that. If you were verbally abusive
and you used foul language and offended attendants on a
regular basis that's an issue. If you are physically
abusive, you know, maybe you bit your attendants, you know,
all of these things would be reasons that home care agencies
would say: We don't want to be working with you.
Now, each of them may -- these may have happened for
various reasons and it's important to sit down with the
individual to figure out what was actually going on and how
can we make this different?
And this is where we look at the process called safety
planning, moving on to Slide 25.
So, when you're in a transition planning meeting, they
always scream fire in the middle of the transition planning
meeting. Absolutely every time. For those who have done it,
you know that this comes up. And it will be -- said
something along the lines of Mary just isn't safe in the
event of a fire. I am telling you, please, please, please
do not respond with well, who is? This does not sell -- this
does not sell you as a good plan for folks.
Instead develop a safety plan.
Now, moving on to Slide 26. What is a safety plan? A
safety plan is a written plan that shows the potential
certains about safety have been considered and addressed.
Within this plan.
Now, this plan is essentially a consumer-driven
alternative to a negotiated risk agreement. So for folks
who are familiar with assisted living and those settings, a
lot of the times, those -- those places will make you sign
an agreements scenially that says in the event that these
things happen you have the right to kick me out.
T not a very, you know, consumer-driven process, in
fact, it's really very hostile, because they say we're not
responsible. We're not liable.
What we did was when we were confronted with these
kinds of problems we flipped the issue on its head. We
said: Okay. And how can we solve these issues and give the
individual more control?
Now, the safety plan is not a guarantee of safety.
Okay. Be realistic. It's a plan.
So, when the person moves into the community, you
know, it doesn't guarantee that they will always have
assistance or the plan will always work as written, but what
it does do is address a very real issue of liability.
Because people are concerned.
If we let someone go out into the community,
particularly from the nursing facility per respect ti, and
that he don't have -- and there isn't a plan that's
reasonable, there is serious liability associated with that.
And this is a tool that you can use, again, to help
the individual address these critical issues and put them in
control. And for me I'm not one who likes a lot of forms
and paper. That fact, I actually -- I hate paper.
It just takes over my world.
So I try to figure out ways to avoid forms, as much as
I can.
But in this case, I thought it was helpful to sort of
document my things and get them written down.
So, being the computer geek that I am I simply took a
full -- a piece of lined paper and folded it in half and
wrote: Issue on one side, and solution on the other.
And that becomes the basis of the safety plan.
So what you want to do is identify with the individual
what are the things that we need to address. What are the
things that people are saying.
And honestly, I think here's where you're having a
conversation with the individual. Many of these are issues
that the person doesn't feel are serious or that they're --
they're significant. But, you know, your sister a very
concerned about your safety in the community. Maybe you
feel that you don't need back-up or have a plan for it. But
your sister wants to know what you'll do in the event an
attendant doesn't show up. It doesn't hurt for us to have a
plan for how to do that. And it actually gives you an
opportunity to take control of the process and say how
you're going to deal with it.
And it may knee -- mean that we want to give some
suggestions along the way, but it does put the person in
charge of the process. It's a really neat way of looking at
it.
So if they scream fire in the meeting what do you do?
Moving on to Slide 27.
You know, we did this sort of as an exercise with our
staff here. And we said, okay, so, say -- say fire, what do
you -- what is the solution?
And some of the things that people came up with in the
meeting were: Well, the apartment has fire walls. You
know, so if there's a fire in the building, the fire walls
will protect the person for some time. It has sprinklers.
It has smoke detectors. We can tell the fire department
that there is a person in this place that doesn't transfer
and they need to know that when they come. And you can do
that. It's a solution, we can get the person a personal
emergency response system. In the event of a fire it will
activate automatically and notify 911, you know, the person
can call for assistance.
Or in some cases we've had multiple exits from an
apartment. You know, so we identified, you know, it was
a -- they actually were cute little apartments, you had an
accessible entrance and we put into the plan making the back
door accessible out so that the person could egress in the
event of a fire. So these are all potential solutions.
Moving on to 28. What was interesting about this
exercise was very quiet in the process was my friend Debbie
who doesn't transfer independently getting in and out of bed
and she just let people talk for a while. And she
interrupted the conversation finally and said: Well, you
know, I understand that we're talking about what to do in
the case of a fire, but as someone who can't get out of bed
I'd rather not have a fire in the first place.
So what I loved about that was that she approached the
problem, you think, in a very different Woi. That a lot of
times -- and in fact, it's how our community would look at
it.
Instead of saying, okay, in the event that there is a
fire, this is what we're going to do, she wanted to
identify, and she did, she started listing out. The common
fire hazards that she just is aware of. Because she doesn't
want a fire in the first place.
She talked about the potential hazards of
inappropriate use of extension cords, a personal failing of
mine, but she was very clear. These are the things that I
think about and I pay attention to. You know, one of the
things that has come up is, you know, where the person
doesn't smoke themselves, having attendants smoking in the
apartment or in the house, potential safety risk. So
implementing sort of a no smoking rule. Or in the event
that the person themselves is a smoker, you know, I came up
with the phrase safer smoking I'm not sure what that means
but it means not smoking in bed you know is what I was
trying to get at. So if you're in a position where you
can't get out of the apartment, maybe that's not the time to
be lighting up.
So, looking at the kinds of things you can do to
prevent a fire or to put -- prevent yourself from being
stuck would be a way to do this.
And see, what you have now is a lot of things listed
there who -- which would, you know, potentially be solutions
to the problem. And suddenly people are thinking, wow,
you've thought about this issue. This is how it's done.
And for us it seems like, well, of course. Duh. A
lot of the times people have not thought about these issues
from the perspective of people in the community,
particularly nursing facility staff or family members who
don't have a lot of experience. So although it seems like
it's sort of very basic to us it can be a really big deal to
them.
So moving on to Slide 29. So some common issues
related to safety and planning, I think it's important when
we look at the various things that could potentially come up
that we break the problem down. You know, so when we talk
about fire, you know, the issue is, you know, that the
person can't -- you know, ultimately it's often the person
can't get out of bed in the event of a fire. That's the crux
of it. That's what's -- what the issue is. Potentially
when there's a risk of falling. You know, when is the --
why is the person at risk of falling? Is it the throw rugs?
In the bathroom, are they unstable? When they transfer? Is
it that the apartment's not accessible or the house isn't
fully accessible and they will get out of the wheelchair
because they want to get to something. And that they're
more likely to fall?
And I think when you're developing a plan with the
individual, to do these things, looking at what's important
to them, so, not surprisingly, the woman who was very
interested in having her hair done every week, and that was
a big deal, also loved pink fluffy throw rugs in her
bathroom. I mean, actually not just rugs but there was
rugs, there was toilet covers and shower curtains and oh my
God, everything was actually very, very pink. But one of
the things that happened when she would go to transfer on to
the toilet or into the tub was that, that beautiful fluffy
pink throw rug would get caught between her feet and it
would make her much less stable in transferring. Actually
it was, I said: That is a broken hip waiting to happen.
But still, you know, from her perspective, having a
wonderful pink, cute bathroom was extraordinarily important
to her. So asking her to throw out the rug was kind of like
asking her to chop off her arm. She probably would have
been more willing to do that, actually.
But what we were able to do was say, okay, you know
what? What if we were to paint a fake rug on the floor, you
know, that's a solution here. You know, so listening to her
and finding out what's important but addressing those
issues.
Breaking down the need for 24-hour care.
Okay. So what does it mean that the person needs
24-hour care? Is there a concern about assistance during the
overnight hours? What does that exactly mean? What hours are
support needed? Because there are obviously times when folks
are around, where you don't need assistance, and if you
break that down into the -- suddenly you might realize,
well, you know what? It's not really overnight, and it's not
during the day. The problem is really between eight and 10.
We can't get attendant services at that time. Or, you know,
breaking it down so you have a very clear sense, it's a lot
easier to find something to fill in that two-hour block,
7 days a week, than it is to say: I need 24-hour
assistance.
The need for back-up assistance. When does a person
need back-up assistance? And having a recognition of what is
the need that the person has.
So if a person -- you know, in the event of a -- one
of the things that I talk about where I am is, you know, one
of the bigger problems we're likely to have is an ice storm.
So in the event of an ice storm and the at tent attendant
can't get to you what is it that you need done? And, you
know, there are lots of different solutions. Sometimes the
person just needs to get assistance getting into bed. And
they're fine once they're there.
There are a lot of different solutions to that. One
of the solutions that we found was actually is the County
was trying to figure out how it could use an ambulance crew
to go move an attend dent 40 miles through our city which
was ravaged with an ice storm. I said just send the EMTs
over, they can transfer into bed and her partner can assist
with toileting and everything. There are lots of solutions
but being very concrete.
Medication administration and management. Okay.
There are a lot of things when you break this down. Is it
the issue of identification of medications? You know, did
you have 14 tiny white pills that you can barely see the
markings on? Is that the problem? Is it prompting that you
don't remember to take them, or is it how you get them
administered in terms of is it a shot? Or maybe the rules
prevent the attend dent from putting that pill in the
person's mouth. How do you solve those. And there are lots
of different and unique solutions that you can use for each
of these.
One, I -- I remember, and I didn't know what it was at
the time but when I was first working with folks, one guy
had his -- these pills sitting on a saucer on his kitchen
table, and I didn't understand why they were there. It
seemed a little odd but what he would do is stick his tongue
out and pick up a pill and that's how he administered the
pills to himself. So there are lots of different solutions,
you just have to break it down to figure out what the issues
are.
And then medical monitoring like with diabetes, that's
a big one. The question is: How closely do we need to
monitor? Is there assistant technology or something that can
do this? You know, is it really important to have tight
blood sugar control? You know, a lot of times you want to
look at the balance of these things. Yes, it's better for
your health, but is it really going to make that much of a
difference in your life.
So moving on to Slide 30. I think it's important to
get clarification. If you are unsure what the concern is,
because people will just say things to you, ask. So, for
example, we were working with a nursing facility, and they
said: John is not compliant.
Okay. I get it. He's non-compliant. What does that
mean?
And, you know, we asked them, please, can you be
specific about it? He seems like a -- you know, a stand-up
kind of guy. I didn't see any major issue of the and they
said, well, he won't take his vitamin. Like, okay. I
didn't think that the world rose or falled based on taking a
vitamin, but, you know, hey, they seem to be very upset
about this, and they've labeled him non-compliant. So you
have a conversationment.
So why are you not taking the vitamin? Well,
basically, he says, it's the one thing I can control. It
means very little in my world whether I take the vitamin or
not. It's my ability to say, you know what? You don't own
me.
So now I have a better sense. He wants control in his
life. This is not, you know, he is non-compliant as a
massive problem. This is he's just asserting himself in
this situation. And I have to say, he picked a pretty
unique way to do it and a way that apparently caused them a
lot of havoc and not much impact on him.
Another thing that will -- that people will say is,
and you'll see this in the record, the person requires a two
person transfer. And, un, you're in the nursing facility.
And I've gone in and I meet the guy and okay, so he weighs
82 pounds, he's not frail. Eats actually wiry, you know,
muscle wiry 82 pounds, and he bears weight. And I'm
thinking to myself, okay, I could assist him with one hand,
and they require four. What's up with this?
You know, and they have a home care nurse who says,
you know, I sent a letter to the state saying he requires a
two person transfer. Well, the issue was she just looked at
his file. She never actually looked at him. She didn't
even actually pay attention to the file as far as I'm
concerned, but the issue was, the nursing facility had a
Worker's Comp rule, they wanted to avoid Worker's Comp
claims. People were required to have a two person transfer.
It wasn't actually about him. It was about the nursing
facility's rules.
So, there, I think it's important again to ask
questions and to go -- to go further of the.
Moving on to Slide 31. So when we're doing transition
planning, we get confronted sometimes with very unique
situations, things that you hadn't anticipated, and you may
not actually have an idea how to solve up front. Maybe
people haven't come across this. I think it's important to
start out by being creative. Now that you've actually
broken the problem down, and you -- can see what the issue
is, come up with a creative solution. And I have to say
that one of the, you know, one of the things that --
examples of -- that I like to use is we were working with a
guy, and he -- managing his own attendant services was not
going to work. The traditional agency's for a about a
zillion reasons didn't want to take him on. And we hit the
wall.
So at lunch one day rather than kibitzing about what
have you. I said, okay, I have a situation, I just want to
brainstorm. And a couple of us were sitting around, and I
didn't give any specifics about the person, I just said
these are the things that I'm trying to -- this is where I'm
at. I'm stuck. And we started brainstorming. Some of the
ideas were extraordinarily stupid but there is no bad idea
in Braun storming. And out of the middle of that
conversation we crafted a new service.
We actually designed, you know, came up with a concept
for someone who would be paid to assist the person in
managing their own services.
And it was a really good idea. It actually saves the
state a whole lot of money. It got him out of the nursing
facility. It was a really effective solution. But it came
about because we were creative and we were willing to be,
you know, funny, and feel stupid sometimes just putting
ideas out on the table, no matter what they were.
So being creative and having folks that you can be
creative with is helpful.
And then asking for help. There are people who have
been doing this, experienced folks, at your centers or at,
you know, outside of -- outside of your centers elsewhere,
who have a lot of experience, who have been through this.
Maybe they haven't had your exact situation, but they have a
lot of expense that you can draw on.
So the idea of looking for, you know, asking for help
is really important here. You don't have to come up with
every answer on your own. And in fact, I think it's
important to see ourselves as facilitators that we try to
connect people with answers, we don't necessarily have them
all in our heads.
I think it's also important to recognize that as the
transition date gets closer, people become more anxious.
And I don't mean -- there are some nerves about it and some
people may become more nervous, but there's also -- they
become excited. And I think one of the things that I've
seen is that folks at this point in the transition process
also have something that they may not have had previously,
hope.
So, whereas, they had sort of gotten to the point
where they accepted what was going on in the nursing
facility. They saw it as, you know, this is just -- it just
sort of washed over them. Suddenly, these are all insults
to their humanity. The television in the community room on
my floor is broken. That pissed me off.
So who do I call? Bruce.
Okay. At this point, you know, I could be fixing TV's
in community rooms or helping people get out. I just have
to recognize that those calls potentially become more
frequent as we get closer to transition. This is where peer
counseling and peer support is extremely important and
helpful, giving someone -- someone to talk to and to talk
this through, you know, having -- having them say, you know,
point out that there is an ombudsman program that can work
on these things. And then to channel some of that energy,
okay, you know what? You're right. TV's broken, we've made
the call. What can we do to move towards getting out, what
do we have to do? So those are some of the things that we
can do to really transform the energy and excitement.
I'm moving on to Slide 32.
Discharge planning is a series of meetings. You're
going to involve the consumer, the facility staff, family,
friends, other supports, community-based providers. We
talked a bit about, you know, each of them may come into the
room with their own agenda, their own bias. It's important
for us to work through that.
It is the discharge planning meeting where we get to
review the plan with folks, who we get -- essentially get
their buy-in. We can present what's going on. It's an
opportunity, have them look it over. And they may see
things that you missed or have ideas, particularly when
you're putting a plan out that says this is how we're going
to solve this, it becomes exciting and people who hadn't
necessarily been thinking in that vein say, hey, I have an
idea, I could add this. I don't want you to shy away from
people who are critical because even the most critical
person will help you develop a better plan. 'Cause if
they're cranky and they're saying this is a problem and
that's a problem they have showed you the holesment of when
you fill them, they're not holes anymore. It's a better
plan.
Now, this is where I like to say it's important for
you to know. It's not just what happens in the meeting, but
the preparation that you can do before the meeting as well.
So, as a CEO here, one of the things that I like to do
is go into a board meeting and have some idea what's going
to happen.
We're going to talk about some things. Being
surprised at the meeting and having -- and more importantly,
having the board chair surprised at the meeting always goes
badly. You know, unless it's a birthday cake surprise or
something. But generally surprises at meetings like this
are not happy.
So what you can do is, touch base with folks ahead of
time. The social worker at the facility may have some
feedback for you on what's going on. And you can address
some of that proactively with the person and have those
conversations.
As you're developing the plan, and you're not
presenting the entire plan all at once. You're doing a
series of meetings and pieces of this are coming out and
it's being evolved.
And if you do this, what happens is, it's not that
you're presenting folks with the plan. This is a plan that
everyone is doing together and that you're helping the
individual be the lead-in.
So it's important to really sort of, you know,
facilitate that process and to try to get people's buy-in
particularly if you can before meetings so you can address
problems beforehand with the individual so rather than have
it pop up in a meeting and have everyone caught off-guard
and feel defensive you can actually be more proactive about
it.
Now, inevitably either you're not going to have time
or you're not going to get to someone or maybe someone just
doesn't tell you or they don't think about it until the
meeting and something ugly pops up in the middle of a
transition planning meeting, you know, something other than
the screen player. At that point, you know, maybe you don't
have the answer. You know, you hadn't thought about it.
The individual's feeling defensive, like, oh, God, I
have to have an answer for this right now.
No. It's not like you're leaving the facility at that
exact minute. What you want to do is actually say; you can
say, let's -- John and I will take this back, that's a good
question. We'll look it over and we'll bring that back --
we'll bring an answer back at the next meeting, that's a
very viable answer.
On Slide 33 looking at the day of transition, what
you're going to -- now that you've got a plan that's been
put in place that you've all bought into, what you want to
do is look, you know, on the day of transition, there's a
lot of stuff that has to happen, because you're starting to
implement. You need to rerue your discharge instructions,
get prescriptions so that the person has their meds arranged
and transport the individual, move personal effects, and
help the person settle into their apartment.
This can be, you know -- my hope is that a lot of the
stuff can be done ahead of time so you've got the apartment
in place, and the hospital bed's been delivered the day
before, and you've got stuff there, and there's a week's
worth of groceries maybe already in the refrigerator, you
know, you're extremely on top of things, and the day goes
smoothly. Yea. It's all wonderful. Everyone's happy.
You're taking pictures.
Moving on to Slide 34. I'd just like to say know that
you have -- on the day of transition, know you have the
services in place. Know that something will fall apart at
the last minute, and know you'll get through it.
So, we have never done a transition that I can think
of. Well, maybe one, where everything went smoothly and was
wonderful.
Always something falls apart.
Stay calm. Seriously. Breathe. It helps.
These are the kinds of -- you know, I really -- I say
this because, you know, you can be surprised by this and
become very anxious and upset. And then the person's upset
and anxious, and then all of a sudden you have a very bad
emotional thing going on. It's not necessary. Stay calm.
I think one of my favorite examples about this is, you
know, we were working with a dear friend of mine who had
brittle bone disease who had been in the hospital seven
months and on the day he was supposed to go home with two,
you know, gross, you know, department store bags full of
medications and you know, this complicated plan that had
taken the highest approval in the state to get happen
there's a giant snowstorm. And he's freaking out. 'Cause
he used to be the one who drove us around. He knows what
slippery roads are like and he's thinking I haven't been out
of this bed, you know, I am in danger.
And I looked at him, and I said oh my God, this is so
exciting, we have a snowstorm. No one's going to be driving
more than five miles an hour this is great. And he knew it.
He thought for a second, oh, you're right. No one will be
driving quickly. This ambulance ride is going to be one of
the smoothest and easiest rides I'll have ever had.
So staying calm, breathing and looking for the bright
side in things, pack a lunch and snacks, okay I seem a
little obsessed with food I am. But you're going to be busy
and sometimes a snack can get you through the day
particularly if you need the food with your meds, you or the
person you're working with. So that's important to plan for
that. And then realize that people change their mind. You
know, sometimes people change their mind at the last minute.
It's okay.
It's not a failure on your part. It's what's right
for them at that point in their life. And it's really
important for you to be supportive.
And not look disappointed and in the -- in the -- you
know, obviously you want to provide them with support and
say, you know, is there something in particular you're
uncomfortable with or concerned? It's okay. Just don't take
it personally. It is something that is going to happen to
you.
Transitions can be, as I said transitions can be very
smooth, they're very, very exciting. You know, you are
helping a person reclaim their life. You know, in our work,
you know, there are not a lot of things where you have this
incredible immediate, you know, impact. We've actually had
transitions where we assisted the person in setting some
things up, gave them some essentially benefits advisement,
and then they did a lot of the rest of the work themselves,
and I had stuff coming into my office and saying she was
transitioned and she didn't even tell us, I said, well, she
clearly has it under control. She didn't need to tell us.
So, you know, maybe we should send her some flowers
orring some, you know, it's just very exciting for folks.
Sometimes they get a little over invested in the process if.
You want to let the person lead.
All right. Moving on to Slide 35. The question, it
was an excellent question, probably a little early about
checklists and time frames and things.
Here is a link to the nursing -- the ABCs of nursing
home transition manual. There are a series of checklists in
there that do talk about at three months you should be doing
this and at six months this and one day this. It breaks the
process down, so for folks who haven't done transition --
any transition before, don't have any connections, this is a
good guide.
I think one of the thin that's helpful is these
checklists are meant to be things to sort of jog your
memory. Use them to sort of guide you through the proceeds
says but it's -- again, you're going to -- what's important
is you're working with the vip Wul. And I like to just say
although we have a giantous of things that we've talked
about if you have the housing, the personal assistants and
the money in order the rest of it will follow.
A lost the times you need some creativity to pull the
plan together, but really, and it's about, you know, weaving
together a complete plan. But you have -- if you have those
basics covered. And a lot of times pull your own personal
experience. You have a lot of experience with your own
house, you know what you need, you know, little things like,
oh, we need toilet paper, that's a basic thing, but a lot of
people think of immediately, you know, you know that that
needs to be done. It's just something that will happen and
you're good. But, you know, don't over-think it. But those
tools are really very helpful. We put a lot of stuff
together in terms -- in these that include checklists for
things that you have in the kitchen, because sometimes it
just makes you feel better to have a list to look at. But
this is a great resource.
All right, moving on to Slide 36 we'll open it up for
questions and answers.
>> Female Voice: As a reminder, if you do have a question,
please press seven or Q on your telephone keypad.
(Pause.)
>> Female Voice: The next question. Please go ahead.
>> Female Voice: Hi. We have a question about back-up. I
know you touched on it briefly. But we had a case where a
consumer needed help with medication and doesn't have any family
or friends in the area, and he was denied leaving a nursing home
because he had no back-up. Is there like an alternative that we
could consider for him?
>> Bruce Darling: Okay. So I hear two different things.
Back-up to me means someone who's there when an attendant can't
show up but I'm hearing that the issue might be more about
medication administration?
>> Female Voice: Yes.
>> Bruce Darling: Okay. I think, again, you want to sort of
look at what the issues are related to med administration and I
don't know what meds are, sometimes I happen to know you're in
Syracuse and putting the pill in someone's mouth in New York you
can have, you know, 40 people in your house and no one can put
the pill on your tongue. (Laugh).
Sometimes the issue is injections, I'm not sure what
level of problem you're having.
>> Female Voice: I believe it's just pills.
>> Female Voice: Pills.
>> Bruce Darling: Just the pill. Okay. Well, honestly,
the -- if the -- what we've done as a successful solution to
simple pills, they are simple, you can get a nurse from a
(inaudible) to set up the pills in the set and this is going to
vary from state to stays based on the rules and there's practices
and rules but we can get a nurse to set the pills up in a
immediate I set and opening the pills up and putting them out is
not a violation of. It's not administration. One of the things
with that is you can actually put them on a saucer and the person
can pick them up with their tongue, that is, that avoids --
that -- it seems a little weird but the idea -- the issue is
putting it in their mouth. Some more complicated things are like
insulin.
We've actually, you know, worked with folks where, you
know, they were able to manage with, you know, maybe their
blood sugars ran a little high. They were able to inject,
but they got a standard dose of insulin that was consistent
with what they needed, their blood sugars ran a little high
so they weren't at risk of low blood sugar. The Atlantic
attendants were aware of what the symptoms of low blood
sugar were so they watched for that, but you give a little
to the health side to get more independence. And then I
think you had actually asked about back-up, and I am
looking, I wanted to acknowledge, I am still looking for my
six rules of back-up in New York State. I have them here
somewhere. I was tearing through -- I don't use them very
frequently so I was look going through folds looking for
that, I will email that out to you though.
>> Female Voice: Thank you.
>> Female Voice: Again, if you do have a question, please
press seven or Q on your telephone keypad.
>> Bruce Darling: Okay. And before we -- I just want to add
one other thing to this piece, where the individual was denied
services in this case, I would -- I would -- I would appeal the
decision in writing and send a copy to the Department of Justice.
And file it, you know, with the, work witness individual, file a
Complaint on their behalf because this is a decision that
violated their right to live in the most integrated setting. All
right. I'm sorry. Go on.
>> Female Voice: Were there any web questions that you would
like to address.
>> Tim Fuchs: Yeah, thanks, we have one. Bruce from the
Boston center for independent living, they say: Hi, Bruce,
several times I found myself working with a consumer who has
criminal convictions, which as you identified creates serious
barriers to finding housing. Do you have any specific
suggestions regarding how to negotiate that situation? In
particular, I know it's possible to seal a criminal record. How
helpful is that when trying to find housing solutions?
>> Bruce Darling: Okay, and I haven't got a lot of experience
in sealing a criminal record. My -- you know, in adapting one of
the things we tell people is water around a rock so I try to find
a simpler solution or the easy yesterday solution and one of the
things that we've done is recognize that a criminal conviction
limits the access to housing so you may not be able to get
traditional subsidized housing but it doesn't mean it limits
their access to all housing. So we may find ourselves looking in
other parts of the community that, you know, where the housing is
just cheaper. So it's not as -- you know, upscale in area.
There may be issues of accessibility there. But we have a lot of
housing stock here that's easy to get, you know, first floor
housing where you could get access into apartment -- you know,
into a lower level apartment. So it changes where you -- where
you can go. So you can still use Medicaid dollars to pay
potentially, where we have them to use -- to do home
modifications or to use home modification dollars to get the
access, and it's just going to be, you know, a less desirable
apartment potentially.
That's sort of -- that's been the approach that we've
used primarily, rather than try to seal records and all of
that. Particularly where there's a drug offense, it just --
it's one of the things we have to accommodate in the
planning process.
>> Tim Fuchs: Okay. Thanks, that's the only web question, we
can go back to the phone. --
>> Female Voice: Next question comes from Barbara Elliott.
Barbara, please go ahead.
>> Female Voice: Would you elaborate a little bit more on
community Medicaid? I'm not familiar with that term.
>> Bruce Darling: Okay. Well, what I'm -- the rules for
Medicaid eligibility are going to be did different in the
institution and the community. And depending on your state what
Medicaid will pay for will be different. So on the institutional
side they use a whole different set of institutional rules for
Medicaid. When you move into the community they need to change
you over into their system so you can get prescriptions out in
the -- you can use the community pharmacy, that the home care
agencies can be billed. One of the thing that's important is,
you know, particularly if you're using that, you know, to get
access to stuff you need that day, like potentially paying for,
you know, durable medical equipment or things you need to get
that transitioned over pretty quickly to make sure that that
happens.
So it's a medicate thing, particularly here in New
York, where -- and I know that in other parts of the
country, the eligibility standards on the institutional and
community side are different. So this is something that you
would talk to the folks who do the Medicaid eligibility
process.
>> Female Voice: Thank you.
>> Female Voice: Again, if you do have a question, please
press seven or Q on your telephone keypad.
(Pause.)
>> Female Voice: It appears that we have no further questions
on the audio side.
>> Tim Fuchs: All right. That's our last question, that was
our last question from the web, too. So perfect timing of the
it's 4:29, I'm afraid it's time to wrap up for today. Bruce,
excellent job, I've clicked over here to Slide 37 where you've
been generous enough to offer your contact information. And then
I'm going to go ahead to Slide 38. For those of you on the
telephone, I have -- I just clicked to the evaluation link. You
can access this by going to the confirmation email, the reminder.
It will take you to the training page and there you can access
the evaluation form for part three. If you're on the webinar the
slide is a Live Link, you can click right on that and again the
evaluation form is really easy to complete. It's very short but
it's really important that we know what you thought. So this
concludes part three. And we will be meeting again for the final
episode in a series next Wednesday at the same time. That's
October 12th. Bruce, thanks again for an excellent presentation,
and thanks to all of you for joining us. If you have any
questions that you think of before next week pertaining to
today's presentation, I'm happy to offer myself as a
point-of-contact. That's Tim at NCI L.org or you can contact
Bruce and get the information on Slide 37. Thanks very much,
everybody. Have a wonderful afternoon. Bye-bye.
>> Female Voice: That concludes today's webinar. You may
disconnect your line at this time.

(Hanging up.)
(End of call.)
(4:30 PM CT.)

\*\*\*\*\*\*\*\*
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