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ASPN

Adult Services Practice Notes

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by

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*The aspen is perhaps the world's
largest organism. Although some
aspen forests cover acres and seem to
be composed of individuals in all
stages of life, they share a common
root system.*

*ASPN: Adult Services
Practice Notes* is
dedicated to providing
information on excellent
family-centered social
work practice with adults
and their families.

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A Letter from Karen Gottovi

Hello, and thank you for this opportunity to make your acquaintance and begin our working relationship. While I've had the chance to work directly with many of your agencies' directors and members of the Older and Disabled Committee of the North Carolina Association of County Directors of Social Services, this is the first opportunity I've had to address DSS adult services staff members directly since our merger.

As you know, seven months ago, what once were two separate entities, the Adult Services Section of the Division of Social Services and the Division of Aging, combined to become the Division of Aging and Adult Services. Our new name not only reflects the merging of program administration and the state staff, but also the merging of our shared goals, missions, and messages.

As I read this issue of *ASPN* before it went to press, it occurred to me that our merger process is in a place similar to Mr. Pirelli's. We also began with our "checklist for change," developed goals, implemented strategies and activities, and assigned people to take responsibility. Now, it's time to take a look back at what's been accomplished (and believe me, that's been plenty), and look ahead to new goals. The process of reassessment that this good social worker is doing with Mr. Pirelli is going on for us too.

What's ahead? Being on the front line of service delivery, you know firsthand many of the challenges we're facing in North Carolina—retirees moving into the state in record numbers, many without family support; a huge increase in the 60+ population as baby boomers age; mental health reform and the movement of older and disabled adults from institutional care to communities, and implementation of a strategy to develop long-term care services, to name just a few. I suspect you could add much more to the list; and your ideas and thoughts are welcome as the Division of Aging and Adult Services moves forward to help you meet the mission of serving older and disabled adults in your community.

Karen E. Gottovi
Director
Division of Aging and Adult Services

Looking for Outcomes

In the last two issues of *ASPN*, you read about Mr. Pirelli and how he, his daughter, and the social worker planned changes in his life that would allow him to continue to live well and safely at home. Based on a thorough assessment, they identified areas for change, set goals, made plans, and began working on them.

Now comes the exciting part—looking at short-term outcomes. In the Family Assessment and Change Process, we have reached the left side of the circle, where monitoring and reassessment are the activities that begin to reveal outcomes. If the client and family have accomplished a goal when you review their progress (at least quarterly and perhaps

(continued next page)

more often), it comes off the list, and that's a positive outcome. Progress toward a goal, even if it hasn't been achieved, also counts as a positive outcome. Readiness to work on new goals is a positive outcome.

When it comes time for reassessment, you and the client and family will look over the original checklist for change, check off the goals you have accomplished together, and set new ones if you need to. If all goes well, the outcome might be termination—the client and family are managing well enough that they no longer need help from the DSS—and this, too, is a positive outcome. Even sad endings can reflect positive outcomes. If work with the client and family ended because the client died, but the client's wishes were honored, that can also be a positive outcome. In this issue, we will follow Mr. Pirelli's progress through monitoring and reassessment, and, on the way, highlight the Special Assistance In-Home (SAIH) Program, which helps people needing adult care home-level assistance remain in their homes. In the next issue, we'll look at ending work with Mr. Pirelli.

What's New with Mr. P.?

There have been some real victories since Mr. Pirelli and the social worker began working together. The first problem on the checklist for change, his weight loss, was resolved by December. Within a few weeks, he had gotten new dentures. His daughter taught him how to cook some of his favorite things before she left, and he takes pride in making them. He also began going to the senior center for lunch through the congregate meals program. One of the senior center staff members talked to him about his interests and then introduced him to some other people who wanted to learn to play bocce, and he has started some in-house teams. The center in the next county over has challenged them to a match in the spring. He has met some of his neighbors, and his children send him phone cards regularly, so he talks to them a few times a week. Although he still misses his wife, his outlook is beginning to brighten. The one exception to the good news is his continuing difficulty with arthritis. His physician suggested knee replacement, which they scheduled for late December, when one of his sons could take a few days to be with him while he was in the hospital. The plan was that he would be discharged to a rehabilitation facility and then home.

The surgery went well. Joseph, Mr. Pirelli's son, stayed for a week and saw him transferred to rehabilitation. Mr. P. arranged for the Boy Scout who had been helping with the gardening to look after his house while he was away. His neighbor, Mrs. Chan-

der, brought him the mail every few days and told him the news from the neighborhood. Some of his senior center friends sent cards and visited. Nevertheless, though he has been working hard in physical therapy, his recovery is slow.

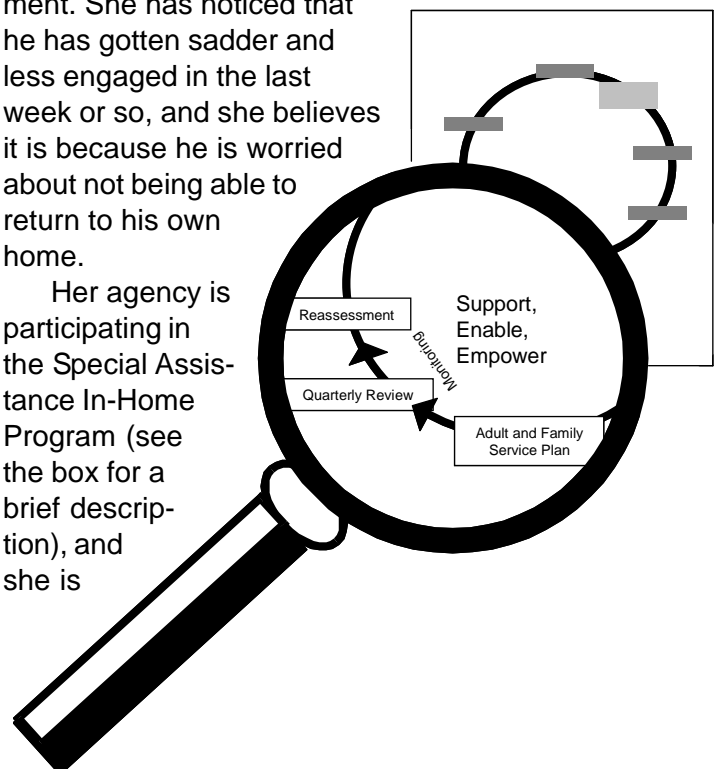
Medicare will pay for one month in the rehabilitation facility, and that time is almost up. The discharge planner talked to him about moving into assisted living. Even though she was very nice and volunteered to take him around to visit the the adult care homes in the area, this really made him sad and even more determined to go home as soon as possible. His physician is willing to sign an FL-2 and has urged him to consider that option, but Mr. Pirelli doesn't want to lose the friends he has made, his house, or the opportunity to work in his garden.

Mr. Pirelli's social worker has been monitoring his progress about monthly since April, in person or by telephone. Because her county uses the Adult Services Record-Keeping Tools, she has kept track of his status on the Interim or Quarterly Client Review. You can see a copy of Mr. Pirelli's record at <http://ssw.unc.edu/cares/nlet/pqrpt.pdf>. (A blank tool in Word format is there as well, <http://ssw.unc.edu/cares/nlet/qrev.doc>. Incidentally, the *Guide to Record Keeping in Adult Services Social Work* is available in .pdf format through the link at http://www.dhhs.state.nc.us/dss/afs/afs_hm.htm.)

Time for Reassessment

Because of the extensive changes in Mr. Pirelli's life that have resulted from his surgery, his social worker thought it might be time to do a complete reassessment. She has noticed that he has gotten sadder and less engaged in the last week or so, and she believes it is because he is worried about not being able to return to his own home.

Her agency is participating in the Special Assistance In-Home Program (see the box for a brief description), and she is



The Special Assistance In-Home Program

In 1999, the NC General Assembly approved a demonstration project using Special Assistance funds to allow eligible older and disabled adults to remain at home rather than enter assisted living. Clients participating in this program had to be eligible for Medicaid; require care in an adult care home, as documented on an FL-2; and undergo a comprehensive assessment and develop a care plan with the case manager. Twenty-two county DSSs applied for inclusion in the project. Over the next two years, 377 people received this assistance and its case management services. During that time, the state paid an average of \$426 per month to support people in adult care homes, and \$184 per month to help participants in the demonstration remain at home, representing a cost saving to the state of \$2.8 million.

Some 84 percent of participants had primary caregivers who provided an average of 35 hours per week of care. However, 52 percent of SAIH recipients lived alone. Although substantial numbers of clients needed some help with activities of daily living, relatively few required extensive or total assistance (from 16 percent for personal hygiene to 4 percent for eating). However, with instrumental activities, far more required assistance, particularly in doing housework (81 percent), shopping (88 percent), or getting around the community (93 percent).

For state fiscal 2003–04, the General Assembly authorized expansion of this program to 800 slots, and 61 counties applied to participate. For more information, contact Jackie Franklin, Special Assistance Program Manager, at (919) 733-3677 or Jackie.Franklin@ncmail.net. To learn more about the demonstration project, see the report to the General Assembly (January 2003) at <http://www.dhhs.state.nc.us/dss/docs/SADP.pdf>

one of the case managers. Based on her original assessment, she believes he meets the income qualifications, and she thinks that using the computerized assessment for that program would serve much the same purpose as the usual adult services reassessment tool in gathering updated information on his status. She describes the program to him and asks if he would like to apply for it. He says yes, and she arranges for him to talk to one of the income maintenance workers and complete the application process.

Mr. Pirelli meets the income eligibility requirements for the program, so he and his social worker go through the SAIH assessment (RAI/HC), which reveals unmet needs the program can address. They develop a new plan based on that assessment. You can see the revised Adult Services Plan at <http://ssw.unc.edu/cares/nlet/pirplan2.pdf>. Some of the activities reflect strategies developed before Mr. Pirelli's knee replacement to help him get through rehabilitation. Others are designed to help him make the transition home after he is discharged and to regain the mobility and flexibility that will allow him to care for himself and his home and participate again in the activities he has come to enjoy. Also, although he now communicates regularly with his children, he and his social worker want him to have people to check in with locally, both to

maintain his social contacts and for emergencies.

Through his participation in the SAIH Program, he is able to purchase LifeLine services. He also uses some of the funds to reimburse his neighbor, Mrs. Chandler, who drives him to the grocery store once each week and who telephones to check on him after dinner. The social worker arranges for him to have an hour each morning of aide services to help him with personal care for the first two weeks he is home. She also helps him identify someone to build a ramp with handrails for his front door (a one-time expense), and he pays the Boy Scout who looked after his house to come once a month to do chores around the house and yard.

It Takes a Village

Hillary Clinton popularized the notion that it takes a village to raise children. A quick glance at Mr. Pirelli's story and the initial findings for the SAIH program suggest that a village is also crucial to helping disabled adults remain at home as long as possible. Because eligibility for the SAIH program is based on income, it is not surprising to find that most of the funds are spent to assure the basics of life—housing, food, and medicine. However, the study of participants in the two-year demonstration project identified how much help they received from informal caregivers. The case studies at the end of the report on the demonstration project show people living alone and continuing to thrive under the program. In many cases, the key may be that they have sufficient support from regular DSS services and from other sources they develop with the help of the case manager. Kelly Blankenship, member of the ASPN editorial board and a social

Mr. Pirelli, continued

worker in Harnett County who has clients in both the SAIH program and in-home services, estimated that her SAIH clients who lived alone were receiving an average of 30 hours a week of services, whether formal or informal. You may want to consider whether the same is true for your clients.

The key to long-term care in the future will likely be the development of what the *2003–2007 State Aging Services Plan* calls “senior-friendly communities.” Part of this vision is development of appropriate services to support the needs of adults with disabilities, but it also relies on strengthening the bonds among

neighbors, friends, and relatives. As you help clients and families identify areas for change, set goals, develop strategies, and locate the formal and informal resources, you help develop communities that support their members, regardless of their abilities, and that is a very good outcome indeed.

For more on senior-friendly communities, see the *2003–2007 State Aging Services Plan* online at www.dhhs.state.nc.us/aging/sasp2003.pdf

Visit the CARES web site at <http://ssw.unc.edu/cares/cares.htm>
for on-line copies of this newsletter, updated calendar of workshops,
links to background materials for events, and much more.

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**Next time:
Ending Work
with Clients**

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