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Leaving Home Care: Decision Making, Risk Scenarios & Services Gaps in the Home Care System

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About the Gerontology Institute

The Gerontology Institute is housed in the John W. McCormack Graduate School of Policy and Global Studies at the University of Massachusetts Boston. The Institute carries out basic and applied social and economic research on aging and engages in public education on aging policy issues, with an emphasis on income security, health (including long-term care), productive aging, and basic social and demographic research on aging. The Gerontology Institute is home to the New England Pension Assistance Project, the National Pension Lawyers' Network, and the Osher Lifelong Learning Institute, a learning-in-retirement program in which members have access to more than 50 courses, lectures, and special events each year. For more information about the Gerontology Institute, visit http://www.umb.edu/gerontologyinstitute

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INTRODUCTION

Home and community-based services (HCBS) enable older and disabled adults to age-in-place in their homes and communities by helping them function independently for as long as possible (Grabowski et al., 2010; Wong & Silverstein, 2011). Previous studies well document that older adults prefer receiving HCBS rather than institutional care at a nursing home (e.g., Walker, 2010; Fox-Grage, Coleman, & Freiman, 2006). Medicaid is a major source of funding for long-term care. Currently, a large proportion of Medicaid funds in most states has been spent on institutional care (National Conference of State Legislatures & AARP, 2009), and older adults and their families have relied on nursing homes to be the provider of long-term care (Miller, Allen, & Mor, 2009). The purpose of this research is to provide additional insights to policy decision makers on the need to rebalance long-term care spending in Massachusetts by further exploring the reasons elder clients are terminated from home- and community-based care.

Care managers are key personnel in providing HCBS to elder clients and have unique insights regarding HCBS. This study builds on qualitative research conducted by Wong and Silverstein (2011) by further exploring the themes that emerged from the previous study related to termination triggers, gaps in HCBS, and the identification and roles of key decision makers in the termination process. In addition, this study examined risk scenarios that may trigger discharge from home- and community-based care programs into institutional settings.

METHODOLOGY

Data were collected through an electronic survey of care managers across the Commonwealth of Massachusetts. The instrument, designed using Survey Monkey®, consisted of 24 closed-ended and 9 open-ended questions. A total of 471 respondents participated in the survey in March 2011, yielding a response rate of 52%. The respondents were a highly educated and relatively homogeneous group with the majority of the respondents female (93%), white (89%), and having attained Bachelor's Degrees (70%). The average age of the respondents was 45 years and the average

length of time the respondents had worked in HCBS was 9 years. Sixty-six percent of respondents indicated that they had specialized training in working with older adults.

RESULTS

Gaps in HCBS and Triggers to Termination

In the opinion of most respondents (76%), services in their region were "somewhat sufficient" as opposed to "very" or "not at all" sufficient. Nearly half of the respondents (47%) reported that their elder clients "somewhat often" disagreed with the decision to be terminated from HCBS and placed into nursing facilities. The greatest gap in HCBS perceived by the respondents was a lack of 24/7 supervision/monitoring (81%), followed by a lack of informal supports (70%), and a lack of adequate state funding for community-based services (64%). Most of the respondents (61%) stated that the cost of a care plan is not a factor in deciding if an elder client should be terminated from HCBS.

Among scenarios that respondents reported "very often" contributed to HCBS termination, the most frequently reported was the need for round-the-clock 24/7 supervision or cueing (86%), followed by insufficient informal family supports (52%) and the need to manage complex medical conditions (49%). Less than 2% of respondents reported that they do not face any gaps in HCBS when trying to maintain elder clients at home.

Health and Physical Functioning

Alzheimer's disease (96%) and dementia other than Alzheimer's disease (86%) were overwhelmingly reported as the two most challenging medical conditions to manage at home, followed by cerebrovascular accident/stroke (45%) and incontinence (35%). Wandering outside of the home was the behavior most frequently reported (63%) as "very much" contributing to HCBS termination followed by clients who were disoriented or cognitively confused (46%) and who resisted care or were self-neglectful (42%). Medications management was highlighted as a concern with the majority of respondents (56%) noting that there were issues with elder clients' medications management that often result in termination from HCBS. Yet, most respondents believed that their elder clients were either "very compliant" (38%) or "somewhat compliant " (59%) regarding taking medications according to their doctor's orders. Physician contact with home- and community-based service staff was limited, with

nearly 67% of respondents reporting that they “rarely have contact” (56%) or “never have contact” (10%) with their elder clients’ doctors.

Decision Makers in the Termination Process

Respondents believed that family members had the major input into the termination decision (73%), followed by elder clients themselves (52%), their doctors (36%), and the respondents themselves— the ASAP workers (12%). Just over half (51%) of the respondents believed that they as workers have “some input” and, nearly 37% believed that they have “not much input” into the termination decision. Many of the respondents (65%) reported that they do not typically learn of the termination decision until after the older adult is institutionalized.

Risk Management

The practice of risk negotiation agreements includes the elder client, his/her family, and the care manager agreeing on what the acceptable level of safety/risk is for the elder client to remain at home. Over a third of the respondents (38%) reported that they were not sure if their agency used risk negotiation agreements, while 35% stated that their agencies did use such agreements. Thirty-one percent of the respondents reported that the elder clients’ families (31%) usually determine if the elder clients are safe at home. Nearly 31% of respondents indicated that risk was determined by a combination of key decision makers that included “*team effort*,” “*consensus*,” “*collaboration*,” and “*interdisciplinary*.” Respondents who reported that elder clients “somewhat often disagree” with the HCBS termination decision were more likely to report that the elder clients’ family members were the key decision makers on whether or not elder clients were safe to remain at home. Respondents who reported that elder clients who “do not often disagree” with the decision to be terminated from HCBS and placed into nursing facilities were more likely to report that the elder clients themselves were key in determining safety and acceptable risk.

Perceived Benefits of HCBS and Nursing Homes

The respondents were asked to list what HCBS can offer that nursing homes cannot and vice versa. A major theme that the respondents perceived that HCBS can offer was greater personal or individual attention. For example, one respondent wrote that HCBS can offer “*One on one attention and no stigma that they are ‘being put away.’*” Other common themes were that HCBS provides *“a familiar home environment”* and “*a*

sense of independence and control." Most of the respondents reported that in their opinion, nursing homes can offer better or more 24/7 care than what is available in HCBS. In addition, nursing homes can offer more "*intensive*" or skilled nursing care such as occupational or physical therapy. Others mentioned that nursing homes can provide more medications management services than can be received in HCBS.

DISCUSSION

Lack of 24/7 Care

A lack of 24/7 care in HCBS was a major theme that emerged, and respondents felt a need to increase the awareness of, and capacity of, available services to supplement the need for 24/7 care. Many respondents perceived that nursing homes can offer better or more 24/7 care than what is available in HCBS. The need for 24/7 care is particularly relevant to the challenges noted in managing persons with Alzheimer's disease (96%) or with a dementia other than Alzheimer's disease (86%). Respondents stressed the need for increased overnight and weekend services in HCBS.

Issues with Informal Supports

Seventy percent of respondents indicated that a lack of informal supports was a major gap that HCBS face and 52% believed not having sufficient informal support was a trigger to terminate elder clients from HCBS and to place them in institutions. Most home care clients live alone, but may have informal family supports within commuting distance (Wong & Silverstein, 2011). However, a lack of informal supports also could be a result of caregiver burnout, especially if the elder client has a challenging medical condition to manage at home such as Alzheimer's disease or a related dementia.

Elders' Role in Care Planning

Two-thirds (67%) of respondents said that their elder clients "somewhat often" or "often" disagree with the decision to be terminated from home care. Respondents who reported that elder clients "somewhat often disagree" with the decision to be terminated from HCBS and placed into nursing facilities were more likely to report that the elder clients' family member(s) determined if elder clients were safe at home (rather than the worker, elder client, or elder clients' doctors). Given that the home-care program seeks to give clients a greater role in determining their own care plan, the lack of engagement by the elders in decision-making and where elders disagree with decisions is worth further exploration.

Medications Management and Conditions

Over half of the respondents (56%) reported there were issues with medications management that typically trigger termination from HCBS to a nursing home. Moreover, 49% of respondents believed that complex medical conditions "very often" pose as triggers to terminate elder clients from HCBS (45% believed it "somewhat often"). In addition, 57% reported that a lack of medications management was a gap in HCBS to maintain elder clients in their homes.

The Issue of "Safety" and Acceptable Risk

After family, respondents noted a combination of key stakeholders in the termination decision. These responses indicated that the decision regarding elder clients' safety involves more than one person (elder client, elder client's family, ASAP workers, and elder client's doctors) and that communication is necessary and likely frequent in order to determine safety. But the larger question in a consumer-empowerment model is: Should elders be playing the most central role in determining what level of risk is acceptable for staying at home? It appears that other parties besides the elder are making the determination about "safety" based on varying criteria. Is the current system giving elders an opportunity to accept some level of risk, and some level of possible failure in their care plans? How should the client's cognitive limitations affect their control over these decisions? These are areas that also warrant further exploration.

Lack of Communication with Medical Community

Nearly 67% of respondents indicated that they "rarely" or "never" have contact with the elder clients' doctors. This is a major concern, because more communication with the medical community may be needed to ensure that the clients' medical care and functional care are carefully coordinated. The state's development of 'medical home' practices presents an opportunity for increased coordination between physicians and community care coordinators (Commonwealth of Massachusetts EOEHHS, 2010).

CONCLUSION

While most respondents indicated that services in their region were "somewhat sufficient," they noted the lack of 24/7 supervision and monitoring, and the lack of informal supports as the greatest gaps they faced in trying to maintain older adults in their homes. A majority stated that the cost of a care plan is not a factor in determining whether an elder client needs a nursing facility (61%); however, many respondents also

noted a lack of adequate state funding for community-based services. The results suggest that there are service gaps in home- and community-based programming but that elder clients today are remaining in their homes and communities longer than in prior years. These findings add to our understanding of ASAP workers'' perceptions of HCBS and the implications for improved policy to reflect the wishes of clients to receive the care of their choice.

INTRODUCTION

According to Chen and Thompson (2010), increases in life expectancy coincide with increases in the length of time long-term care services will be needed. Consequently, longer life expectancies compounded with record numbers of older adults in the coming years will put extra strain on the availability of all long-term care services, specifically home- and community-based services (HCBS). There are two main goals of HCBS: to support older and disabled adults' abilities to age-in-place in their homes and communities and to help such adults function independently for as long as possible (Grabowski et al., 2010; Wong & Silverstein, 2011). In 2007, approximately 2.8 million people participated in HCBS programs nationwide, an increase of nearly one million participants since 1999 (Kaiser Commission on Medicaid and the Uninsured, 2011). In 2006, the national average of the proportion of Medicaid long-term care spending for disabled older adults and persons with disabilities going to institutional care was 75%, while 25% was directed towards HCBS (Kassner et al., 2008). Similar to the national average, the proportion of Medicaid long-term care spending for institutional care in 2006 was greater than the proportion for HCBS in Massachusetts, with 78% of Medicaid long-term care spending directed towards institutional care, and 22% going to HCBS (Kassner et al., 2008). Moreover, in 2007, Massachusetts had nearly a 25% greater rate of nursing home utilization than the national average (Wallack et al., 2010). As of 2008, according to the Massachusetts State Profile Tool, approximately 60% of MassHealth (Massachusetts' state Medicaid program) long-term care spending is spent on nursing facilities. The purpose of this research is to provide additional insights to policy decision makers interested in rebalancing long-term care spending in Massachusetts by further exploring the reasons elder clients are terminated from home- and community-based care.

Existing literature reported in Wong and Silverstein (2011) revealed that older adults generally prefer receiving home- and community-based care versus receiving long-term care services in institutional settings. The authors note that previous studies well document that older adults prefer receiving HCBS rather than institutional care at a nursing home (e.g., Walker, 2010; Fox-Grage,

Coleman, & Freiman, 2006). One study concluded that 84% of older Americans, aged 50 years and older want to remain in their homes for as long as possible (AARP, 2005). Medicaid is a major source of funding for long-term care. Currently, a large proportion of Medicaid funds in most states has been spent on institutional care (National Conference of State Legislatures & AARP, 2009), and older adults and their families have relied on nursing homes to be providers of long-term care (Miller, Allen, & Mor, 2009). Several aspects of HCBS have been studied, including long-term care specialists' views in support of expanding HCBS (Grabowski et al., 2010), factors that affect utilization of HCBS and perceived service needs (Chen & Thompson, 2010; Tang & Lee, 2010), and frail older adults' unmet needs in HCBS (Casado, Van Vulpen, & Davis, 2011). Limited research, however, has examined HCBS from the perspective of direct care staff.

In Massachusetts, the home care programs are administered by Aging Service Access Points (ASAPs) under contract with the Executive Office of Elder Affairs (EOEA).The EOEA is the State Unit on Aging. The EOEA provides home care services through contracts with 27 ASAPs throughout the Commonwealth. ASAPs are described as a single entry point for elders in the community. Services provided by ASAPs include care management, information and referral, nursing home pre- and post-admission screening, development of service plans, and monitoring of service plans. In 2010, there were over 42,000 older adults served by the ASAPs through three major home care programs offered in Massachusetts (Wong & Silverstein, 2011).

Care managers are key personnel in providing HCBS to elder clients and have unique insights regarding HCBS. Specifically, care managers are involved directly in assessing clients' individual service needs and creating and providing service plans through home care funded service programs (Wong & Silverstein, 2011). Care managers are also part of a team as they work with ASAP nurses, supervisors, and additional ASAP staff such as protective service workers and options counselors. The additional ASAP staff complements the work provided by care managers to assess elder clients through an interdisciplinary and comprehensive approach to providing HCBS and maximizes the effectiveness of the services. The team also includes the clients' informal supports (such as family and friends) that are often incorporated in the

service plans and assist in developing the personalized care plans (Wong & Silverstein, 2011).

Wong and Silverstein (2011) study included in-depth interviews with 18 care managers in Massachusetts about their perceptions of HCBS termination to institutional settings. The current study builds on the Wong and Silverstein (2011) research by further exploring the themes that emerged from the previous study. The major themes from the prior research related to termination triggers, gaps in HCBS, and the identification and roles of key decision makers in the termination process. In addition, this current study examines risk scenarios that may trigger discharge from home- and community-based care programs into institutional settings.

METHODOLOGY

Gerontology students at the University of Massachusetts Boston, College of Public and Community Service, designed and conducted the study reported here. The study was conducted in partial fulfillment of requirements for undergraduate and certificate gerontology students. Data were collected through an electronic statewide survey of care managers. Institutional Review Board (IRB) approval was obtained through the University of Massachusetts Boston in January 2011. As part of IRB approval, all of the students underwent training and received the online Collaborative Institutional Training Initiative (CITI) certification in order to conduct research involving human subjects (Training & Education, 2011). In addition, the protocol was reviewed and approved by the Mass Home Care Board of Directors in January 2011 as Mass Home Care served as the Community Partner for this study. An electronic survey was designed using Survey Monkey® and consisted of 24 closed-ended and 9 open-ended questions that focused on the major themes described in the research questions. The survey was available from March 4, 2011, to March 25, 2011. The Community Partner, Mass Home Care, sent an email to a listserv of Executive Directors of 27 Massachusetts Aging Service Access Points (ASAPs) describing the study and included a link to the survey. ASAP Executive Directors were then asked to disseminate the introduction to the study and the link to the survey to all of the direct-care staff members. Weekly reminders about the survey were also sent to the Executive Directors. The survey took

approximately 17 minutes to complete. A total of 471 respondents participated in the survey, yielding a response rate of 52%, which has been reported in the literature as a good response rate for an electronic survey (Instructional Assessment Resources, 2010). Since this was an exploratory study with a convenience sample, the analysis is limited to descriptive statistics. Response percentages (%) and response values (n) are presented. The data were imported from Survey Monkey® to a Microsoft® Excel spreadsheet and then imported to SPSS version 18.

Research Questions

The major research question was: What are care managers' perceptions on reasons clients are discharged from home- and community-based care to institutions?

The sub-questions included:

- What scenarios trigger discharge from HCBS into institutions?
- What gaps do HCBS face in Massachusetts?
- Who are the key decision makers involved in the decision to terminate clients from HCBS?

RESULTS

Sample Description

The respondents were a highly educated and relatively homogeneous group with the majority of the respondents female (93%), white (89%), and having attained Bachelor's Degrees (70%). The average age of the respondents was 45 years and the average length of time they had worked in HCBS was 9 years, with 50% having worked at least 6 years (range of less than 1 year to 30 plus years). The respondents were from all six regions of Massachusetts. Central Massachusetts had the highest percentage of respondents (27%), followed by the South Shore (19%), Metro West (19%), Western Massachusetts (14%), the North Shore (13%), and Greater Boston (8%).

Sixty-six percent of respondents indicated that they had specialized training in working with older adults. The specialized training reported included educational settings (courses, certificates, minors or concentrations, continuing education units

[CEUs], and degrees such as Geriatric Nursing and Social Work); and agency settings (workshops, in-services, conferences, on the job training, volunteering, and internships).

The target population for the survey was care managers and, in fact, over sixty-two percent of respondents were care managers, either ASAP care managers (54%) or care manager supervisors (8%). Most of the respondents (67%) worked directly with elder clients, either as an ASAP care manager or as an ASAP RN (13%) while the remaining job titles (care manager supervisor, home care program manager, and RN supervisor) were in supervisory or managerial positions that typically do not require direct contact with elder clients. “Other” job titles (18%) frequently listed included: geriatric support services coordinator, protective service workers, options counselor, and assessment specialist.

To gauge the respondents’ perceptions of changes in nursing home placement rates in recent years, respondents were asked to comment on nursing home placement rates with their current caseloads relative to when they first started working in the field of elder care. The majority of respondents (67%) indicated that they thought elder clients are maintained longer in the community now than before. Only 3% thought that clients were discharged sooner to nursing homes from the community.

Gaps in HCBS and Triggers to Termination

Figure 1 displays the respondents’ opinions of the sufficiency of services in their regions. They were asked to indicate their subjective measure of “very,” “somewhat,” or “not at all” sufficient. Most of the respondents (76%) believed that services were “somewhat sufficient,” followed by “very sufficient” (14%) and “not at all sufficient” (10%). The 10% (46 respondents) that reported services as “not at all sufficient” in their regions were asked to list what services were lacking. Common responses included a lack of funds, lack of 24/7 or overnight care, lack of transportation, lack of affordable housing or assisted living facilities, problems with medications management, lack of mental health services, end-of-life care, and emergency respite services. There was not a significant difference in the level of sufficiency of services reported by region.

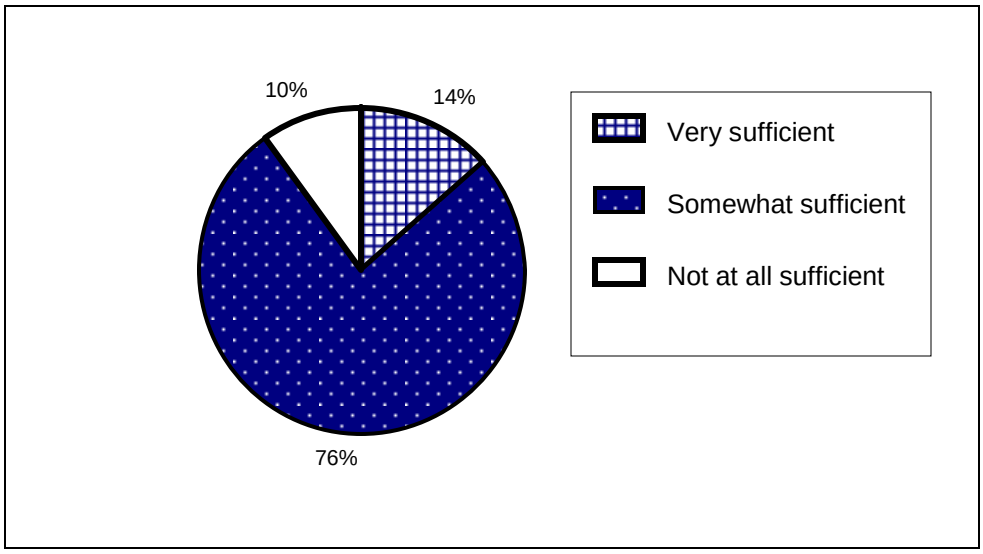

Figure 1. Sufficiency of Services (n=453)

The respondents were then asked their opinions on how often elder clients disagree with the decision to be terminated from receiving HCBS and placed into a nursing facility. The majority (67%) of the respondents reported that their elder clients "often disagree" (20%) or "somewhat often disagree" (47%) with the decision to be terminated from HCBS, and a third reported that clients "do not often disagree."

Consistent with the "list of services lacking" reported above, Table 1 illustrates the greatest gaps in services respondents stated that they face when trying to maintain elder clients in their homes. Respondents could report more than one gap. The greatest gap reported was a lack of 24/7 supervision/monitoring (81%), followed by a lack of informal supports (70%), and a lack of adequate state funding for community-based services (64%). Less than 2% of respondents reported that they do not face any gaps in HCBS when trying to maintain elder clients at home.

Table 1. Greatest Gaps in Services to Maintain Elder Clients at Home (n=455)

Gaps in Services	**% (n)**
Lack of 24/7 supervision/monitoring	80.9% (368)
Lack of informal supports (family/friends)	69.7% (317)
Lack of adequate state funding for community-based services	64.4% (293)
Lack of cueing and supervision for people with dementia	60.9% (277)
Lack of medication management	56.9% (259)
Lack of community or in-home behavioral health services	39.6% (180)
Lack of appropriate housing	28.6% (130)
I do not face any gaps in services to maintain elder clients in their homes.	1.5% (7)
Other [1]	10.8% (49)

[1]Nearly 11% of respondents (n=49) indicated "other" gaps in services including a lack of: "*reliable communication from provider agencies*," "*transportation*," "*supportive equipment*," "*overnight care*," "*respite care*," "*end of life care or last stage illness programs*," "*reliable vendor workers*," and "*doctors/medical professionals who make visits to homes*."

Respondents were then asked to consider situations that might trigger termination. Table 2 displays the scenarios that respondents reported "very often" contributed to HCBS termination. The need for round-the-clock, 24/7 supervision or cueing (86%) was the most frequently reported scenario followed by lack of sufficient informal family supports (52%) and complex medical conditions (49%). Scenarios that "somewhat often" contributed to HCBS termination included clients having a sudden change in their functional capacity and required hospitalization (51%) followed by behavior that has become very aggressive or hostile (46%) and overall care needs that become too costly to maintain the client at home (41%). Respondents were also asked to list other scenarios that might trigger HCBS termination and placement into a nursing facility. Other scenarios mentioned included: clients' or families' wishes for clients to enter a nursing home, death of caregiver, caregiver burnout, not enough state funding for HCBS, falls, lack of supportive homes, lack of elder clients' funds for an assisted living facility, and advance directive.

Table 2. Scenarios that Trigger Termination from HCBS and Placement into a Nursing Facility (n=432)

Scenario	Very often	Somewhat often	Not at all often
Requires round the clock, 24/7 supervision or cueing	85.5% (365)	13.6 % (58)	0.9% (4)
Does not have sufficient informal family supports	51.5% (218)	41.6% (176)	6.9% (29)
Has complex medical conditions	49.0% (205)	44.5% (186)	6.5% (27)
Behavior has become very hostile or aggressive	38.8% (162)	45.9% (192)	15.3% (64)
Overall care needs have become too costly to maintain client at home	38.3% (159)	41.2% (171)	20.5% (85)
Has had a sudden change in their functional capacity and required hospitalization	37.1% (156)	51.0% (214)	11.9% (50)
Unable to provide for his or her own daily personal care	32.6% (137)	37.4% (157)	30.0% (126)

Health and Physical Functioning

The medical conditions perceived by the respondents as most challenging for elder clients to manage at home were overwhelmingly Alzheimer's disease (96%) and dementia other than Alzheimer's disease (86%) followed by cerebrovascular accident/stroke (45%) and incontinence (35%). Other challenging medical conditions reported by respondents offered through an open-ended question included: mental health illnesses or issues (such as drug or alcohol addiction), multiple sclerosis, Parkinson's disease, and cancer.

Table 3 illustrates behaviors reported as contributing to termination from HCBS. Wandering outside of the home was the behavior most frequently reported (63%) as "very much" contributing to HCBS termination followed by being disoriented or cognitively confused (46%) and resisting care or being self-neglectful (42%). In terms of behaviors that contribute "somewhat" to termination from HCBS, being verbally abusive to others was the most reported (56%) followed by resisting care (50%) and being disoriented (50%).

Table 3. Behaviors that Contribute to Termination from HCBS (n=428)

Behavior	Very Much	Somewhat	Not at all
Wandering outside of home	62.8% (267)	29.6% (126)	4.5% (19)
Physically abusive to others	41.0% (170)	41.2% (171)	8.9% (37)
Verbally abusive to others	10.1% (41)	55.8% (227)	21.4% (87)
Disoriented, cognitively confused	45.8% (193)	49.6% (209)	3.1% (13)
Resists care or self-neglectful	42.1% (177)	50.2% (211)	6.0% (25)
Feelings of depression	2.9% (12)	45.8% (187)	42.9% (175)
Feelings of suicide	21.0% (86)	37.1% (152)	20.0% (82)

Medications management is critical to remaining independent in the community. Respondents were asked to assess the level of compliance their clients have with medications management according to their doctor's care plan. Overall, most respondents (97%) reported that their elder clients were either "very compliant" (38%) or "somewhat compliant "(59%) regarding medications. Less than 1% believed their elder clients were "not at all compliant."

Greater insights are gleaned, however, from the narrative responses to open-ended questions on medications management. Respondents were asked to expand their comments on issues with medications management that typically trigger termination from HCBS to nursing homes. The majority of respondents (56%) reported that there were issues with elder clients' medications management that result in termination from HCBS. Several themes emerged from the narrative responses. Many respondents reported that elder clients often have physical impairments that inhibit proper medication compliance. For example, one respondent noted:

> "*Elder Clients who have hearing and vision deficits may not be able to self manage medication, despite being cognitively alert and oriented. Homemakers and Home Health Aides are not permitted to dispense medication. Medication reminder equipment is only usable by clients who are cognitively and physically able to hear a bell and see the container*."

Similarly, another respondent wrote:

"*Elders have difficulty seeing medication labels. Many know what they should take but cannot physically see well enough or open the containers to take the medications*."

These quotations illustrate that physical limitations pose a serious problem to medications management and compliance, and that assistive devices fall short of helping clients with some disabilities. Moreover, a major issue with medication management involved insulin. Similar to the examples provided above, several respondents noted that elder clients often had difficulty self-injecting insulin for diabetes.

The respondents noted that some elder clients forget to take or are confused about their medications. Although some clients have mild cognitive impairment or memory less, others have a progressive dementia such as Alzheimer's disease. Still, many do not know the correct dosages or the correct times to take their medications while others forget to take their medications on a regular basis altogether. As one respondent wrote:

"*There is the issue of polypharmacy and many MDs over prescribe medications to elders who cannot handle meds physically, emotionally, and financially*."

Another reported that "*The more complex the medication regime becomes, the more likely the elder is to not take their medications properly*." Many respondents noted that clients who were confused or unclear about their medications were at risk for overdosing or mixing medications, which are major safety issues. Elder clients with behavioral issues can also pose a risk for negative issues with medications management.

Another recurrent theme was the affordability of medications, in general, and how the costs relate to medications management:

"*Individuals [who] have MassHealth and can get assistance for medication management have better chances for staying in the community. Medicare does not pay for medication management, and beyond having workers in buildings cueing the consumer, there is no vehicle to provide this service.*"

Another respondent wrote that a "*lack of informal supports to assist with medications and a lack of budget for formal skilled agencies to assist*" were issues with medications management related to the financial burdens and the need for support to help oversee proper management. Elder clients who have difficulty with medications management were also more at risk of being placed into hospitals due to overdose or complications, which may incur other costs to clients in addition to creating safety issues.

Related to medications management and compliance, the respondents were also asked about the level of contact ASAP staff had with their elder clients' doctors. Nearly 67% of respondents reported that they "rarely have contact" (56%) or "never have contact" (10%) with their elder clients' doctors. Less than 2% reported "continual contact" and 31% reported "occasional contact."

Decision Makers in the Termination Process

Respondents were asked to rate the level of input key stakeholders had in the termination decision process as "much input," "some input," and "not much input." In terms of "much input," respondents believed that family members had the major input into the termination decision (73%), followed by elder clients themselves (52%), their doctors (36%), and the respondents themselves—the ASAP workers (12%). Just over half (51%) of the respondents believed they as workers had "some input" and nearly 37% believed that they had "not much input." Interestingly, nearly two-thirds (64.8%) of the respondents reported that they typically learned that an elder client had been placed into a nursing facility after the fact. Of that amount, about half of these respondents (32%) learned of the nursing facility placement "within days," but still after the decision had been made.

Respondents were then asked to identify the person who usually informed them that an elder client had been placed in a nursing facility. Over half of respondents (52%) reported that a family member of the elder client usually informed them, followed by "other" (22%) and the ASAP RN (12%). "Other" included: hospital or hospital discharge planners, provider or service agency, or a combination of the informants listed. Some

respondents indicated that they are directly involved in the process of placing an elder client into a nursing facility so that the question was not applicable to them.

Risk Management

The ability to age-in-place in the community is often a question of the balance between safety and acceptable risk. Respondents were asked to identify the people who determine if the elder clients are safe at home in order to provide key insights regarding risk management.

As seen in Figure 2, most respondents (31%) reported that elder clients' family members usually determine if the elder clients are safe at home. Nearly 31% of respondents indicated a combination of decision makers such as "*team effort*," "*consensus*," "*collaboration*," and "*interdisciplinary*." Several respondents also indicated "*protective services.*"

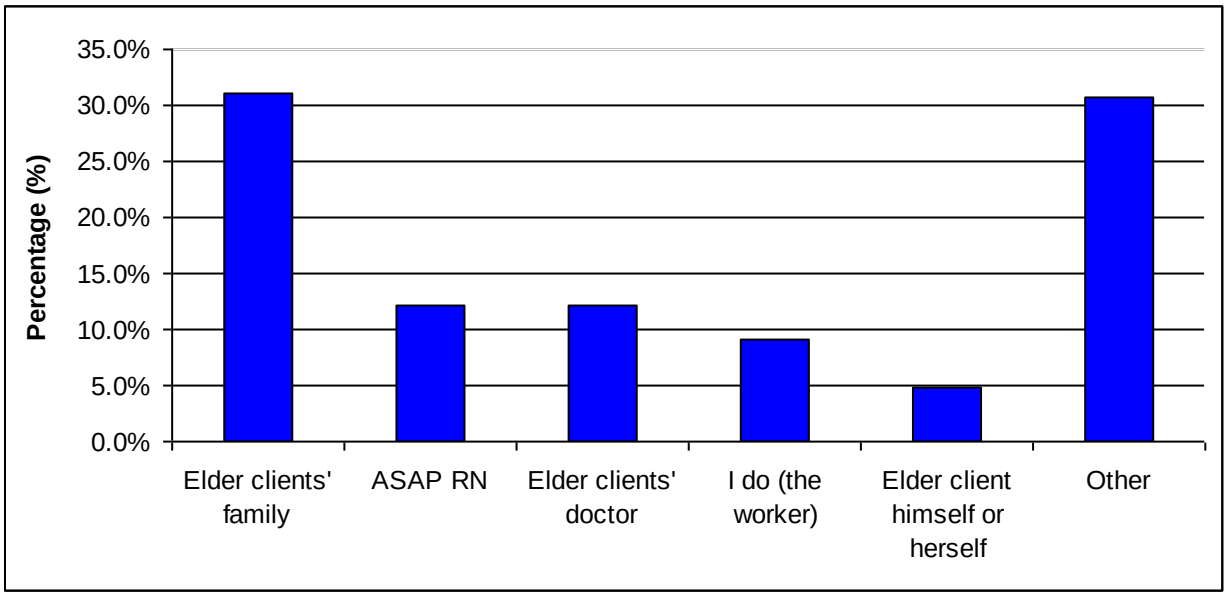

Figure 2. Person who Determines if Elder Client is Safe at Home (n=429)

Respondents were also asked the extent to which the length of time an elder client is left alone during the day and night contributed to termination from HCBS and placement into a nursing home. This item was included in the survey because of the predominance of persons with cognitive impairment and the high risk of wandering behavior (Silverstein, Flaherty, & Tobin, 2002). For both day and night, the majority of respondents (53%) reported that the length of time an elder client was left alone during

the day and night "somewhat" contributed to HCBS termination, followed by "very much" (23% for day and 26% for night) and "not at all" (17% for day and 14% for night).

Respondents were also asked to comment on the cost of care and whether or not a cost factor contributed to a termination decision. Table 4 depicts cost scenarios that may affect the decision to place elder clients in nursing facilities when the respondents note that they are participating in the decision to terminate elder clients from HCBS. Respondents could select more than one answer. Most of the respondents (61%) reported that the cost of a care plan is not a factor in deciding if an elder client needs a nursing facility. Nearly 24% indicated none of the scenarios contribute to their role in decision-making recommendations. Respondents were asked to comment on this item, and many wrote that the decision is based more on safety than money. For example, one respondent wrote "*Decisions are based on elder being able to safely remain at home*" while another wrote:

> "*Although the cost is a major factor, the main issue is safety at home. We strive to keep the elder at home as long as it is safe to do so."*

Other responses included program eligibility and availability of services; still others noted that elder clients' and their families' wishes are greater factors than the cost of the care plan. One respondent wrote: "*Each case is viewed on an individual basis."*

Table 4. Cost Scenarios that Affect Decision to Place Elder Client in a Nursing Facility (n=412)

Cost Scenario	**% (n)**
If a home care plan costs more than a nursing home, I am less likely to consider continuing home care.	7.8% (32)
If a home care plan costs less than a nursing home, I am more likely to consider continuing home care.	16% (66)
The cost of a care plan is not a factor in deciding if an elder client needs a nursing facility.	61.4% (253)
None of the above	23.5% (97)

Risk Negotiation Agreements

The practice of risk negotiation agreements includes the elder client, his or her family, and the care manager agreeing on what the acceptable level of safety/risk is for the elder client to remain at home. Respondents were asked if their agencies had risk negotiation agreements in use with their clients. Most respondents (38%) reported that they were not sure if their agency used risk negotiation agreements. Nearly 35% of respondents indicated that they do use risk negotiation agreements at their agency, and 27% reported that they do not. Respondents were asked to furthercomment on this item. Some respondents reported that risk negotiation agreements are only for MassHealth[2] clients or clients who are the "*most fragile and complex*." Some interpreted risk negotiation as risk management, that is, steps taken to reduce risk rather than the level of risk the elder and or family members are willing to accept. One respondent wrote that they assign "*risk numbers*" while another wrote,

> "*We do assess for risk and do discuss this with clients and families, but do not have an official risk agreement negotiation form*."

Others were unfamiliar with risk negotiation agreement terminology prior to this survey item. Many respondents wrote that their agency had "*risk assessments*" but not risk negotiation agreements. One wrote risk negotiation agreements are "*being developed*." Appendices A and B include the Risk Level Assessment Worksheet and Risk Assessment Form recommended by the Massachusetts Executive Office of Elder Affairs.

Perceived Benefits of HCBS and Nursing Homes

There was an inherent bias toward maintaining older adults in HCBS settings. While acknowledging that bias, we asked the respondents to consider the benefits of each, home- and community-based, and institutional settings. Specifically, through an open-ended narrative question, respondents were asked to list what HCBS can offer that nursing homes cannot. Several prominent themes emerged. A major theme was that HCBS can offer greater personal or individual attention when clients receive services. For example, one respondent wrote that HCBS can offer "*one-on-one attention and no stigma that they are 'being put away'*." Another respondent reported that HCBS can

[2] MassHealth is the name for Medicaid in Massachusetts.

provide "*care more tailored to individual*." Both of these responses demonstrate the theme of personalized and individualized attention and services from home- and community-based care settings.

Another prominent theme was that HCBS can provide a greater sense of privacy since clients remain in their homes. As one respondent described, HCBS can provide a "*meaningful, familiar, comfortable environment*" in the privacy of one's own home or community, which is related to the goals of HCBS for clients to age in place. HCBS allow memories to be preserved while an elder client remains in the privacy of his or her home or in the community, in addition to a more "*normal, homelike environment"* that can often not be achieved in an institution. In addition, one respondent reported that HCBS can offer "*asset protection.*"

The respondents noted that HCBS also facilitates elder clients contact with their informal support systems. Many respondents perceived that contact with informal support, such as family and friends, was more frequent with HCBS. In addition, some respondents mentioned clients' pets as part of their informal support system. As one respondent described, "*The consumer can remain in a familiar environment and continue to be with their pets*." Many respondents also mentioned that HCBS allow for a greater "*connection to community*," which is also related to clients' informal supports.

Independence, freedom, control, and choice were additional themes from the responses. For example, "'*Choice to have some influence on where and how you get to receive care*,' '*autonomy*,' and '*individuality' "* were all frequently reported. One respondent reported that HCBS provide "*A sense of dignity and empowerment to remain in one's home with adequate services to ensure safety and well-being*" while another said that "*At home the elder can exercise choice about his or her day to day life which are not possible in an institutional setting*."

Of the 317 narrative responses offered, only one respondent reported that HCBS can offer "*nothing*" that nursing homes cannot. Another respondent reported: "*Every case is different. There is a NEED for more Nursing Homes. Some elders CANNOT remain safely in their homes and have no family supports*."

Respondents then provided their thoughts regarding the services that nursing homes can offer that HCBS cannot. Overwhelmingly, 24/7 supervision, oversight, care, and safety were the most frequent responses. With 24/7 care at nursing homes, one respondent reported that clients were "*more likely to have medical issues addressed in a timely fashion, especially if elder is hesitant to call PCP or family or has little to no informal contacts in the home*." One respondent said that there is "*no vendor availability*" for overnight supervision and that there is "*not enough vendor availability*" for weekend services in terms of HCBS while nursing homes can provide such services 24/7.

Some respondents perceived that the environment of a nursing home can also provide greater safety than HCBS. One reported that nursing homes were "*Certainly better equipped in an emergency*" while another wrote that there is greater "*access to help quickly"* in nursing homes. Another respondent mentioned how the "*locked facility*" is something that HCBS cannot provide for elder clients. Similar to the safety that the nursing home environment can provide, nursing institutions can also offer a "*special environment for special populations, for example, Alzheimer's unit."* Within the nursing home environment, some respondents believed that more "*intensive*" care such as occupational or physical therapy services can be provided to nursing home residents. Others mentioned that nursing homes can provide more medications management services than HCBS. "*Consistency in care*" was also mentioned, detailing that more staff at nursing homes allows coverage of shifts if there is a problem with a worker not coming into work. Another respondent wrote that there was "*more communication and collaboration with home based care organizations*."

Several respondents noted that nursing homes can offer a greater sense of socialization and activities that HCBS cannot. For elder clients who do not have informal support systems, nursing homes can help facilitate connections with others. For elders who do have informal supports, nursing homes can also provide "*caregiver relief*."

DISCUSSION

Lack of 24/7 Care

The lack of 24/7 care in home- and community-based services was a major theme that emerged from several of the items in the survey. It is clear that there is a need to increase the awareness, and capacity of available services to supplement the need for 24/7 care. Nearly 81% reported the lack of 24/7 care as one of the greatest gaps in trying to maintain elder clients in their homes. In addition, 86% reported that elder clients requiring round-the-clock, 24/7 care is a trigger scenario that can result in the decision for the elder client to be terminated from HCBS. In the open-ended item regarding what nursing homes can offer that HCBS cannot, 291 respondents reported that nursing homes can offer [better or] more 24/7 care than what is available in HCBS, the most frequent response provided. The lack of 24/7 care is consistent with the interviews conducted and journal notes reviewed in the Wong and Silverstein (2011) study.

The need for 24/7 care is also related to how 96% of respondents indicated that Alzheimer's disease and 86% indicated that other dementias are challenging medical conditions to manage at home. In addition, 63% of respondents reported that wandering outside of the home "very much" contributed to termination from HCBS and placement into a nursing home, more than any of the behaviors listed. HCBS are currently working on creating complex care teams of HCBS personnel to specialize in 24/7 care cases (A. Norman, personal communication, June 27, 2011). It is clear, however, that overnight and weekend services in home- and community-based care should be expanded if the goal is to help people remain in their homes. These are two important benefits of nursing home care that many respondents noted believing that HCBS cannot provide these benefits as readily. Some respondents perceived that the environment of a nursing home can also provide greater safety than HCBS. This is worth further exploration, since the goal of providing care in the "least restrictive setting" is to reach a point where home- and community-based services can be expected to provide the same "safety" and set of services that could be found in a nursing facility. Some level of risk will be present in any setting—home or facility. Within the nursing home environment, some respondents believed that more "*intensive*" care such as

occupational or physical therapy services can be provided to nursing home residents. Again, this perception among home care workers should be discussed further.

Many of the respondents raised concern over the cost of providing 24/7 round-the-clock care. As one respondent wrote, "*If 24/7 care could be provided inexpensively by home and community based care, more older adults would stay in their homes*." This study does not explicitly address the cost of not providing 24/7 care but implies that providing more funding for 24/7 care would allow for more HCBS workers proactively to prevent unsafe wandering behaviors, in addition to other costly consequences that occur due to a lack of 24/7 care (e.g., falls, medications mismanagement). Moreover, greater availability of 24/7 care can also supplement the lack of informal supports, which was the second most reported gap in HCBS. It is also consistent with the mission of MassHealth, as found in Chapter 118E, Section 9, which is to keep elders living in the least restrictive setting appropriate to their needs.

Issues with Informal Supports

Several studies have examined caregiver support and delayed institutionalization. According to Castora-Binkley et al. (2010), if caregiver services were utilized, institutionalization of care recipients can often be delayed. In addition, Mittelman et al. (1996) demonstrated that counseling and support can delay institutionalization for spouses with Alzheimer's disease because the caregiver is able to care for the spouse longer at home. Seventy percent of respondents indicated that a lack of informal supports was a major gap that HCBS face, and 52% believed not having sufficient informal support was a trigger to terminate elder clients from HCBS and placement in an institution. A lack of informal supports could be a result of caregiver burnout, especially if the elder client has a challenging medical condition to manage at home such as Alzheimer's disease or dementia.

However, from the responses, there appears to be ambiguity with informal supports. Although elder clients' families had reported as having "much input" in the decisions to terminate from HCBS (family was reported as having "much input" more than the elder client, the worker, and the elder client's doctor), the large amount of family input may be due to clients' impairment (Alzheimer's disease or dementia).

Alzheimer's disease and other dementias themselves might limit the clients' abilities to communicate their wishes. The ambiguity exists in that several respondents reported that their elder clients did not have sufficient informal supports to be maintained in the home/community, while also reporting that the elder clients' families had the largest amount of input in the decision to terminate HCBS. More research is needed that is sensitive to the varying levels of informal support existing among the HCBS population.

Medications Management and Conditions

Over half of the respondents (56%) reported there were issues with medications management that typically trigger termination from HCBS to a nursing home. Moreover, 49% of respondents believed that complex medical conditions "very often" pose as a trigger to terminate elder clients from HCBS (45% believed it was "somewhat often"). In addition, 57% reported that a lack of medications management was a gap in HCBS when trying to maintain elder clients in their homes. Elder clients who have difficulty with medications management may also be more at risk of being placed into a hospital due to overdose or complications, which may incur other costs to the client in addition to creating safety issues.

Risk Negotiation Agreements

There were word choice issues and varying levels of comprehension regarding the risk negotiation agreement item. It is clear, however, that there should be consistency among the 27 ASAPs regarding the assessment of level of acceptance of risk for the elder client to remain at home. The Executive Office of Elder Affairs (EOEA) has recognized the need for a risk program to better serve elder clients' needs. Recently, the EOEA put into effect a risk management program among the ASAPs (Appendices A and B). The risk identification and management forms contain various aspects of risk including health risks/daily care needs (e.g., need for oxygen, avoiding falls), behavioral risks (e.g., non-compliant, substance abuse, anxiety), and risks to personal safety (e.g., socially isolated, financial risk). Based on health, behavioral and personal risk factors, the risk level for the elder client will be assessed (level 1 is critical, level 2 is high risk, level 3 is moderate risk, level 4 is low risk). The elder client/guardian will sign the form showing that he/she understands the risk and responsibility associated with the risks

outlined. These risk identification and management forms will likely help strengthen communication with the various parties involved.

Across all job categories, most workers said they had only “some” or “not much” input in the decision to terminate an elder from home care. Given the importance of this decision, this should be an item for further discussion among ASAPs. The central question of whether elder clients are being given the right to fail by selecting a care plan that includes more risk than that which is acceptable to their workers is one which needs further exploration. Workers’ opinions about what is “safe” for the elder client may be at odds with the client’s willingness to accept the risk to remain at home. This is where risk negotiation agreements become a useful care planning protocol.

Weighing Safety against Right to Fail

Only 5% of respondents believed that their elder clients determine if they are safe at home, which overwhelmingly suggests that the determination of level of safety risk acceptance is not made by the individual most affected by the decision.

Two-thirds (67%) of respondents said that their elder clients “somewhat often” or “often” disagree with the decision to be terminated from home care. Since elder clients are expected to play a central role in this major life decision, more research and discussion should take place among ASAPs regarding why respondents answered in this fashion. Further research should focus on changes in protocols that should be made to ensure that elders are being given the opportunity to have more say in the termination decision. Given that the home care program seeks to give clients a greater role in determining their own care plans, the lack of engagement by elders is worth further exploration

The larger question in a consumer-empowerment model is: Should elders be playing the most central role in determining what level of risk is acceptable for staying at home? It appears that other parties besides elders are making the determination about “safety” based on their own criteria. Is the current system giving elders an opportunity to accept some level or risk, and some level of possible failure in their care plans? In a system that seeks to foster consumer-directed care, the issue of who determines

"safety" vs. the capacity of the elder client to take some risks should be discussed further. What are the mechanisms in place to address clients with diminished capacity?

More Communication between Doctors and Home Care Workers

Across all job categories, at least 50% or more of respondents said they "rarely" or "never" have contact with their clients' doctors. This makes coordinating the medical plan of care with the functional plan of care very difficult. For this particular item, it is clear that the respondents lack a sense of communication with their elder clients' doctors, who are not only key determinants in the decision to terminate HCBS (36% reported that the elder clients' doctors had "much input" in the decision to terminate HCBS), but also key in determining if the elder client is safe at home (12%). Furthermore, a lack of communication was evident regarding when respondents learn of nursing facility placement. Nearly two-thirds (65%) of respondents reported that they learn of a nursing facility placement after if happens. Of that amount, 32% reported that they learn of the nursing facility placement "within days," but still after the decision has been made. If care planning between medical and functional care were truly integrated, the home care workers would be part of the decision-making process with the elder client, his or her caregivers/family, and medical professionals.

One of the few items that elicited a strong sense of communication among the elder clients, workers, ASAP RNs, elder clients' family, and elder clients' doctors was the question regarding the person who determines if the client is safe at home. "Other" was reported as the second most frequent response, and such responses included phrases such "*team effort*," "*consensus*," "*collaboration*," and "*interdisciplinary*." These responses indicated that the decision about elder clients' safety involved more than one person and that communication was necessary and likely frequent in order to properly determine safety. It is imperative to have a strong sense of communication within the medical community to ensure clients' utmost safety and that all parties involved are aware of the decisions. The advent of 'medical homes' in Massachusetts is an opportune moment for policy makers to improve the level of coordination between medical and functional supports. (Commonwealth of Massachusetts EOEHHS, 2011).

Overall gaps in HCBS

Although the results indicated that the respondents perceived that elder clients remain in the home and community longer than before, respondents indicated that service gaps remain in home- and community-based programming. Over 64% of respondents believed that a lack of adequate state funding for community-based services represents a gap when trying to maintain elder clients in their homes. However, 80% of respondents believed that "too costly" care needs were "somewhat often" or "very often" triggers for termination from home care, which appears to contradict the response of 61% of respondents who said the cost of a care plan was not a factor in determining whether an elder needed a nursing facility. As of 2009, according to the Executive Office of Health and Human Services, 66% of MassHealth long-term care spending is on institutional care. (MA Executive Office of Health and Human Services, 2011). Although nursing facility patient days have declined -29% in the past decade (Mass Home Care, 2011), a 'rebalancing' of spending from nursing facilities to home care would help to address the funding shortfall barrier identified by the respondents. The overall findings suggest that minimizing the gaps in home- and community-based services would help maintain more elder clients in the home and delay or forgo institutional settings.

STUDY LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

This was a descriptive study with a convenience sample. Thus, caution should be exercised in interpretation of the findings. There were several limitations. First, the survey was designed for care managers as the target respondents. As noted in sample description of the results, several different titles of ASAP workers responded, with ASAP care managers representing 54% of the survey respondents. While the respondents were all ASAP staff members, not all had carried direct caseloads. Therefore, some of the questions likely did not apply to all respondents.

Second, the data are based on ASAP workers' perceptions rather than analyses of actual cases involving their elder clients. This was an unfunded research study conducted under the auspices of an undergraduate gerontology program with cost and time constraints to complete within an academic semester. Future research with additional resources might compare analyses of actual cases to the ASAP workers'

perceptions to strengthen validity of the perceptions. However, the overall perceptions presented in this study are consistent with the data from Wong and Silverstein (2011), which used a smaller sample and different methodology.

Some respondents submitted additional feedback about the survey design in the comments section. A common theme was that respondents had difficulty answering some of the questions from the perspective of considering their overall caseload, that is, not knowing if the elder client "*had capacity*" and that the questions were more appropriate on a case-by-case basis instead. The survey was intended for respondents to think of their elder client caseloads in a general sense, which may have skewed the results if respondents answered questions with only certain clients in mind.

Lastly, all of the respondents were involved in home and community-based services and not in institutional settings. Therefore, a bias exists in which the necessity and value of HCBS is supported by the respondents. Future research might include nursing home staff in addition to HCBS workers. All of the workers were involved in home- and community-based care; therefore, the results may have been biased in favor of supporting and expanding HCBS.

In addition to including long-term care staff from institutional settings, future research might also include family members or informal supports, as evidenced by the large amount of input they have in the decision to terminate HCBS clients into a nursing facility. Finally, exploring the relationship to the medical community more closely could also provide more insights, especially in terms of the interdisciplinary or team approach. As the state experiments with medical homes, a much more integrated approach between medical and functional supports would enhance client care and potentially reduce the use of acute and nursing facility supports.

CONCLUSION

While most respondents indicated that services in their region were "somewhat sufficient," they noted the lack of 24/7 supervision and monitoring and the lack of informal supports as the greatest gaps they faced in trying to maintain older adults in their homes. A majority stated that the cost of a care plan is not a factor in deciding if an elder client needs a nursing facility (61%); however, many respondents also noted a

lack of adequate state funding for community based services. The results suggest that there are service gaps in home- and community-based programming but that elder clients today are remaining in the home and community longer than in prior years. These findings add to our understanding of care managers' perceptions of HCBS and the implications for improved policy to reflect the wishes of the client to receive the care of their choice.

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Appendix A

MASSACHUSETTS EXECUTIVE OFFICE OF ELDER AFFAIRS

RISK LEVEL ASSESSMENT WORKSHEET

Use this worksheet to determine a consumer's Risk Level of 1 through 4.

<table>
<tr><th>RISK FACTORS</th><th>RISK LEVEL</th><th>INDICATORS</th></tr>
<tr><td rowspan="2">Health Risks/Daily Care Need:

1. Needs daily personal care
2. Frequent hospitalizations or ER visits
3. Unstable medical condition(s)
4. Frequent falls
5. Requires daily cueing to take medications and/or an unmet need in medication management
6. Medical treatments are needed to treat or prevent serious injury, an irreversible condition, or death (e.g., oxygen)

Behavioral Risks:

1. Cognitive and/or mental health problems that interfere with daily functioning or judgment
2. Active substance abuse problem
3. Unable to adapt to changes in routines, including service routines
4. Is self-neglecting or non-compliant with essential needs
5. Family/others create challenging dynamic

Risks to Personal Safety:

1. Unresolved Protective Services issues (current or recent involvement with PS, including triage/screen out)
2. Socially isolated and/or hard to serve</td><td>1

Critical</td><td>No Informal Support

and

Health Risks/Daily Care Need

and/or

Behavioral Risks

and/or

Risk to Personal Safety

OR

Services must be provided as scheduled

EMP†: Contact within 1 day</td></tr>
<tr><td>2

High Risk</td><td>Limited Informal Support*

and

Health Risks/Daily Care Need

and/or

Behavioral Risks

and/or</td></tr>
</table>

† EMP refers to the ASAP's emergency management plan.

* Limited informal supports may be physically distant, have infrequent contact, or be inconsistent, inappropriate, or inadequate.

and/or would not reach out for help **3. Would not have extra food and/or medications in an emergency** **4. Inability to self-advocate** **5. Poor safety awareness** **6. Substandard housing or unsafe living arrangements** **7. Finances insufficient to meet basic needs/unresolved money management issues**		Risk to Personal Safety **EMP: Contact within 1 day**
	3 Moderate Risk	Involved, Stable Informal Support **and** Health Risks/Daily Care Need **and/or** Behavioral Risks **and/or** Risk to Personal Safety **EMP: Contact within 3 days**
	4 Low Risk	Involved, Stable Informal Support and Health Risk/Basic Care Plan **EMP: Contact within 7 days**

† EMP refers to the ASAP's emergency management plan.

* Limited informal supports may be physically distant, have infrequent contact, or be inconsistent, inappropriate, or inadequate

APPENDIX B
MASSACHUSETTS EXECUTIVE OFFICE OF ELDER AFFAIRS
RISK ASSESSMENT FORM
(Required for Risk Levels 1 & 2)

Consumer Name: _____SIMS ID: _____

ASAP: _____ ASAP CM/RN: _____

List Specific Risks	What is the team's (consumer, caregiver, ASAP, others) evaluation of the risks?	What preventive measures or supports would minimize risks?	Who helps with preventive measures or supports?

I have read and understand the risks stated above and I accept responsibility for these risks.

Signature of Consumer/Caregiver: _____ Date: _____