Caregiver Module

Commented [SL1]: The module document is a reference for automation. If the CCM tool provides a different method to improve user efficiency (e.g. navigation, workflow, layout) this should be reviewed with the Department for optimization within the CCM platform. This document is a not intended to be automated as is.

Key
Bold Blue Highlight: Module narrative and directions – assessment level instructions and/or help
Orange: Items, responses, and other language specifically for participants 0-17 unless otherwise indicated
Green: Skip patterns
Red: Additional instructions for assessors -item level help
Purple: Section level help
Light Blue: Notes for automation and/or configuration
S **Denotes a shared question with another module (one way only unless otherwise indicated)**
Gray Highlight: Responses/Text Boxes to pull forward to Assessment Output
Yellow Highlight: populate and/or pull forward to the support plan from another module or section within the support plan itself
Green Highlight: Populate and/or pull forward from the member record to an assessment or from an assessment to the member record
Denotes mandatory item
Item populates forward for Reassessment
Teal Highlight: Items for Revision and CSR- Support Plan only
Italics: *Items from FASI (CARE) Department use only*

The purpose of the Caregiver Module of the Assessment process is to assess the level of support provided by paid and unpaid caregiver(s); identify situations when a participant's unpaid caregiver(s) needs relief or additional support; provide important information about how formal services should wrap around what is otherwise being provided and will continue to be provided; and identify if paid supports should be initiated to relieve the unpaid caregiver(s) providing natural supports.

Notes/Comments are present at the end of each section. These are used to: 1) Document additional information that was discussed or observed during the assessment process and was not adequately captured. 2) Document unique behavioral, cognitive or medical issue that were not captured in the assessment items that may increase the need for supervision or support. This narrative can provide additional justification in the event of a case review

1. CAREGIVER INFORMATION

Commented [SL2]: Within the CCM tool numbering for sections and questions does not need to match document, however format needs to be determined by the Department based on CCM design.

This section gathers information about all unpaid and paid caregivers in order to create a total picture about the amount and types of supports provided by individuals and community organizations. This information is valuable for coordinating supports when developing the Support Plan. It is also critical to understanding the capacity of caregivers to continue providing support. Information gathered in this section can come from a variety of sources, including the participant or others providing assistance. This section is used to identify the type, amount and frequency of unpaid support provided by others (family, friends, others, etc.).

Special Instructions for Caregivers of Children

For caregivers of children, the discussion should focus on support that is provided that is beyond what is expected of caregivers of a child of a similar age without disability-related issues.

1. **Does the participant have paid or unpaid caregiver supports?** (This includes IHSS, CDASS, and Family Caregiver programs. This **excludes** other services provided by a Medicaid agency authorized via the Support Plan.)
   - ❍ No (End of module)
   - ❍ Yes

2. Identify Caregiver Supports- Use age appropriate guidelines to identify support provided that is beyond what is expected of a caregiver of a child of a similar age without disability related issues.

Caregiver Information	**Distance from Participant**	**Caregiver Help- Paid** Show for any payment source selected other than "Unpaid"	**Caregiver Help- Unpaid** Show if payment source "Unpaid" is selected	**Frequency: How Often is Assistance Provided**	**Will Support Continue in the Future?**	**Back-up Planning**
Name:_____ Preferred Phone #:___ Preferred Email:___ Caregiver Is: ☐ Regular support ☐ Back-up support	❍ Lives with ❍ Within 5-10 minutes ❍ 15-20 minutes ❍ Longer than 20 minutes	☐ Self-care assistance (for example, bathing, dressing, toileting, or eating/feeding) ☐ Mobility assistance (for example, bed mobility, transfers, ambulating, or wheeling) ☐ IADL assistance (for example, making meals, housekeeping, telephone, shopping, or finances) ☐ Medication administration (for example, oral, inhaled, or injectable medications). ☐ Medical procedures/ treatments (for example, changing wound dressing, or home exercise program). ☐ Management of equipment (for example, oxygen, IV/infusion equipment, enteral/parenteral nutrition, or ventilator therapy equipment and supplies). ☐ Supervision (for example, due to safety concerns). ☐ Advocacy or facilitation of person's participation in appropriate medical care (for example, transportation to or from appointments). ☐ Other advocacy not related to medical care ☐ Assistance with daily (or routine) problem solving ☐ Non-medical transportation ☐ Social opportunities ☐ Other, describe paid caregiver help:____	☐ Self-care assistance (for example, bathing, dressing, toileting, or eating/feeding) ☐ Mobility assistance (for example, bed mobility, transfers, ambulating, or wheeling) ☐ IADL assistance (for example, making meals, housekeeping, telephone, shopping, or finances) ☐ Medication administration (for example, oral, inhaled, or injectable medications). ☐ Medical procedures/ treatments (for example, changing wound dressing, or home exercise program). ☐ Management of equipment (for example, oxygen, IV/infusion equipment, enteral/parenteral nutrition, or ventilator therapy equipment and supplies). ☐ Supervision (for example, due to safety concerns). ☐ Advocacy or facilitation of person's participation in appropriate medical care (for example, transportation to or from appointments). ☐ Other advocacy not related to medical care ☐ Assistance with daily (or routine) problem solving ☐ Non-medical transportation ☐ Social opportunities ☐ Other, describe unpaid caregiver help:____	❍ As needed ❍ Less than once a month ❍ About once a month ❍ About once a week ❍ 3-4 times a week ❍ Once a day ❍ 2 or more times per day, less than continuously ❍ Continuously (ongoing basis or 24hrs/day)	❍ No, cannot continue providing ❍ Yes, can continue providing ❍ Yes, can increase amount of assistance ❍ Yes, need to decrease amount of assistance ❍ Do not know Does a transition plan need to be developed for the caregiver? ❍ No ❍ Yes	**Support source is responsible for arranging back-up** ❍ **No** ❍ **Yes** **What should I do if the support does not show up? Who else can help and how they can help?** **Text field** **Any other concerns I have if my other supports are not available.** **Text field**
Payment Source Responses selected determine whether "Caregiver Help-Paid" and/or "Caregiver Help-Unpaid" columns show	**Relationship to Participant**			**Would the Participant Prefer a Different Caregiver?**	**Does the Caregiver Need Support Services/Training?**	
☐ Unpaid ☐ Self-paid ☐ Paid by other family member/ friend ☐ Medicaid ☐ Medicare	❍ Spouse ❍ Parent ❍ Adult Child ❍ Other family member:___ ❍ Friend			❍ No ❍ Yes, describe different caregiver:_____	❍ No ❍ Yes, describe support services/training needed:_____	

☐ Private LTC Insurance ☐ Private Health Insurance ☐ VA ☐ DVR ☐ Other, describe payment source:__	❍ Neighbor ❍ Other, specify relationship to participant:_					

Additional caregiver tables may be added for as many caregivers as needed.

3. **Notes/Comments: Caregiver Information (e.g. Describe any changes desired in caregiver or any training needed for caregiver.)**

2. PRIMARY UNPAID CAREGIVER INTERVIEW

Only show this Section if "Unpaid" is selected in the "Payment Source" column for ANY of the supports identified in Section 1

This optional section includes items to assist in determining the potential need for caregiver supports or supports to the participant that provide caregiver relief. In some situations, primary caregiving may be shared. The assessor should use his/her judgment about interviewing more than one person.

1. **Caregiver Name:**_____

2. **About how long have you been providing care for the participant?**
   - ❍ Less than 6 months
   - ❍ 6 to 11 months
   - ❍ 1 - 3 years
   - ❍ 3 - 5 years
   - ❍ 5-10 years
   - ❍ More than 10 years
   - ❍ Unknown

❍ Choose not to answer

3. How would you describe your own physical health?
- ❍ Excellent
- ❍ Good
- ❍ Fair
- ❍ Poor
- ❍ Unknown
- ❍ Choose not to answer

If rated "Fair" or "Poor" show this item

3a. Do you believe that caregiving is affecting your overall physical health?
- ❍ No
- ❍ Yes

4. How would you describe your own mental health?
- ❍ Excellent
- ❍ Good
- ❍ Fair
- ❍ Poor
- ❍ Unknown
- ❍ Choose not to answer

If rated "Fair" or "Poor" show this item

4a. Do you believe that caregiving is affecting your mental health?
- ❍ No
- ❍ Yes

5. Since you began providing support, are there things that you are unable to do that you either used to enjoy or had plans to do?
- ❍ No
- ❍ Yes,

  Describe the things that you are unable to do since you began providing support:_____
- ❍ Choose not to answer

6. Are you able to spend time socializing, such as visiting with family/friends or attending events in the community that interest you?

- ❍ No, due to caregiving responsibilities
- ❍ No, not due to caregiving responsibilities (Skip to Item 7- Issues/Obstacles)
- ❍ Yes (Skip to Item 7- Issues/Obstacles)
- ❍ Choose not to answer (Skip to Item 7- Issues/Obstacles)

6a. What are the challenges or barriers that prevent you from socializing with others as much as you would like?

7. Are there any issues/obstacles that make it more difficult to provide support?

- ❍ No
- ❍ Yes
  - ☐ Decline in own emotional health
  - ☐ Decline in own physical health
  - ☐ Feels increased difficulty with managing level and intensity of stress
  - ☐ Does not have necessary training/skills
  - ☐ Employment is negatively impacted
  - ☐ Has other caregiving responsibility
  - ☐ Level of caregiving is too difficult
  - ☐ Need (more) breaks from caregiving
  - ☐ Relationship issues with participant or other family members
  - ☐ Substitute decision-making responsibilities
  - ☐ Finances
  - ☐ Child care for children other than participant unavailable or insufficient for fulfilling family/household responsibilities
  - ☐ Unable to access necessary services
  - ☐ Other,
    Describe other issues/obstacles that make it more difficult to provide support:_____
- ❍ Choose not to answer

8. Additional comments regarding issues/obstacles identified by caregiver:

9. Are you currently receiving any caregiver supports or have you received any in the past?

- ❍ No
- ❍ Yes
- ❍ Choose not to answer

Supports	Current	Past
Caregiver education or conferences	☐	☐
Caregiver counseling	☐	☐
Training	☐	☐
Respite care	☐	☐
Support group	☐	☐
Faith-based group	☐	☐
Caregiver coach or mentor	☐	☐
Financial Supports	☐	☐
Other, describe caregiver supports:_____	☐	☐

Allow for multiple other caregiver supports and description to be added.

10. As the primary caregiver, do you have anyone in your life who helps you when you need it?

- ❍ No (Skip to Item 12- If something unexpected happened)
- ❍ Yes
- ❍ Choose not to answer

11. Can you depend on this person to help you, i.e., is the help routine and available when you need it?

- ❍ No
- ❍ Yes
- ❍ Choose not to answer

12. If something unexpected happened to you, is there a plan in place for someone to provide caregiving?

- ❍ No
- ❍ Yes. If yes, who would that be? _____

13. Are you able to consistently get 5 hours of uninterrupted sleep daily when caring for the participant?

- ❍ No
- ❍ Yes
- ❍ Sometimes
- ❍ N/A
- ❍ Choose not to answer

14. Is there anything that would make it easier for you to provide care for the participant?

- ❍ No
- ❍ Yes
  - ☐ Caregiver education or conferences
  - ☐ Caregiver counseling
  - ☐ Caregiver coach or mentor
  - ☐ Training
  - ☐ Coping with memory care or behavior issues
  - ☐ Help with finances
  - ☐ Direct care
  - ☐ Faith-based group
  - ☐ Finding social networks and supports
  - ☐ Finding services
  - ☐ Family relationships
  - ☐ Home modifications
  - ☐ Accessible transportation
  - ☐ Technology and assistive devices
  - ☐ Hiring my own help
  - ☐ Educational/Recreational overnight activities (e.g., camp)
  - ☐ Respite care
  - ☐ Time for myself
  - ☐ Self-care techniques
  - ☐ Disease and disease process education
  - ☐ Substance abuse or other mental health education

- ☐ Transition supports
- ☐ Other,
  describe what would make it easier to provide care for participant: _____

❍ Choose not to answer

15. Additional comments regarding anything that would make it easier for you to provide care for the participant:

16. Do you have any concerns about caring for the participant?

❍ No
❍ Yes
- ☐ Help managing care needs (medications, treatments)
- ☐ Finding respite
- ☐ Managing memory or behavioral care issues
- ☐ Dealing with family relationships and communications
- ☐ Social activities and support systems
- ☐ Assistance with legal, insurance or financial issues
- ☐ Home modifications
- ☐ Technology or assistive devices
- ☐ Balancing work
- ☐ Family and caregiving responsibilities
- ☐ Ability to continue to provide care as I age and/or cannot provide the same level of physical assistance
- ☐ Other,
  describe concerns about caring for participant: _____

❍ Choose not to answer

17. Additional comments regarding concerns about caring for the participant:

18. Given the participant's CURRENT CONDITION, have you ever considered having him/her in a different type of care setting, such as a nursing home, ICF/IID, hospital, or another care facility for long-term placement?

- ❍ Definitely not
- ❍ Probably not
- ❍ Probably would
- ❍ Definitely would
- ❍ Choose not to answer

19. Indicate whether caregiver wants assistance with contacting a community organization for more information or assistance with caregiving.

- ❍ No. Is already involved with community organization or group
- ❍ No. Does not want to be contacted
- ❍ Yes. Wants to be contacted for help with or training in caregiving
- ❍ Unknown

20. Notes/Comments: Unpaid Caregiver(s)